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 12, Number 1 — April 1992

Spring meetings to look at future of medicare in Britain and Ontario

Two general meetings of the Medical Reform Group have been scheduled to for this May.

The first meeting, on the evening of Tuesday May 19, will look at the National Health Service in Britain. Either Steven Birch and Gavin Mooney will be the guest speaker.

The second meeting, on the evening of Thursday May 28, will have two guest speakers from the newly re-vitalized Ontario Health Coalition, Janet Maher and Lee Zaslofsky, to kick off a general discussion of how to preserve medicare in Ontario and in Canada in the face of the current onslaught.

Both meetings will be evening meetings, and both meetings will take place in Toronto. Details about locations and agendas will be contained in the May issue of *Medical Reform.*

Fee increase proposed

The May 28 meeting will also be the official Spring business meeting of the MRG, which will consider the MRG's proposed budget for 1992-93.

The Steering Committee is proposing that membership fees be increased to $195 from $175 for the 1992-93 fiscal year. Although fees have not been raised since 1989, the Steering Committee is recommending this increase only with reluctance, given the general economic climate. Expenses have in fact only gone up a very small amount, and membership numbers have held steady this year despite some fears that they would suffer as a result of all physicians being drafted into the OMA.

However, members have clearly cut back on discretionary spending, with the result that the total of "Supporting Membership" donations has fallen substantially. In addition, the number of members asking to pay reduced fees because of their financial circumstances has increased. The Steering Committee is therefore recommending that we adopt the option of asking those who can afford to pay more, to do so. This recommendation will be voted on at the May 28 meeting.

Opportunity Knocks

New members are needed to join the MRG Steering Committee as we head into a year which promises to be full of challenging issues.

The Steering Committee meets once a month, with meetings alternating between Toronto and Hamilton.

Membership on the Steering Committee can be a stimulating way of learning about the issues and challenges which are confronting the health care system. Previous experience is not required: all members of the Steering Committee were new to it when they first came on board.

If you are interested in volunteering for the Steering Committee, please contact a current member, call the MRG number at (416) 588-9167, or come to the Spring meetings and volunteer.

INSIDE

Procedures may be cut from OHIP

Ontario's Ministry of Health is reviewing certain procedures which it has labelled as "borderline cosmetic" with a view to deciding whether they should continue to be covered by OHIP. The following procedures are on the list:

- Electrolysis
- Removal of tattoos
- Sex reassignment surgery
- Sterilization
- Reversal of sterilization
- In vitro fertilization
- Reduction mammoplasty
- Augmentation mammoplasty
- Panniculectomy
- Repair of torn ear lobes
- Blepharoplasty
- Septorhinoplasty
- Umbilectomy
- Newborn circumcision
- Male Mastectomy, benign
- Penile Prosthesis for impotence
- Gastric bypass for morbid obesity
- Sclerotherapy
- Dermabrasion
- Psychoanalysis

The MRG Steering Committee discussed this issue at two meetings. The discussions quickly made it clear that this is a complicated issue raising a number of important questions. Time will be set aside at one of the Spring general meetings (Tuesday May 19 and Thursday May 28) to discuss it further. The Hamilton chapter of the MRG has formed a working group to look at it. In the meantime, MRG members are asked to (a) consider the items on the list and the broader issue, (b) send their comments to *Medical Reform* (fax, mail, and computer disks welcome), and (c) propose motions, if they wish, for the membership to vote on (please submit in

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Resource Allocation:

Who should decide and how should decisions be made?

This psoition paper has been prepared by the MRG Resource Allocation Working Group. Members' and readers' comments are invited.

As addressed in the background document which MRG representatives provided to the Minister of Health prior to our December 1991 meeting, the universal, high-quality care that has been the hallmark of the Canadian health care system is at serious risk. The NDP government in Ontario is at risk of falling prey to an excessive focus on cost control. Specifically, if the government restricts health care funding in such a way that services fall below minimal standards and unacceptable queues for beneficial services result, pressures for an alternative health care system will become overwhelming, two-tiered care will be reintroduced, and it will become politically expedient for the government (particularly a non-NDP government at some point in the future) to let the public system deteriorate further.

In this document we briefly outline problems with how decisions are currently being made regarding the allocation of health care resources, outline some strategies for correcting those deficiencies and suggest some practical steps that the government can take immediately to meet the current crisis and, at the same time, have a lasting impact on the health care system that is consistent with the NDP philosophy.

These recommendations are not a "magic bullet" for the perceived crisis in health care spending. We recognize that there are severe economic pressures on the government to reduce spending. At the same time, as a group of progressive physicians, we feel it is incumbent upon us to bring to the government's attention, and the public's attention, the serious risk to our health care system arising from the ways in which decisions about health care spending are currently being made.

It is also worth noting that the way in which decisions are currently being made, driven by financial concerns without due consideration of the consequences of the decisions, is politically damaging to the NDP as well as damaging to the health care system and those most in need of care.

1. Problems with the way in which decisions are made now

1.1 Inappropriate incentives and disincentives

Currently, key decision-makers are likely to be motivated in ways that are in conflict with public interests. For example, politicians' electoral concerns often constrict their vision to a time frame that is limited by the next election and their financial alliances or other exigencies prompt them to focus on cost-containment rather than cost-effectiveness; bureaucrats' career concerns often motivate them to focus on internal political demands rather than health needs; and physicians' economic interests often come in conflict with public interests.

1.2 Inappropriate influence

Various interest groups, particularly affluent ones, have a disproportionate influence on decisions.

1.3 Need for scrutiny

Many resource allocation decisions are now being made behind closed doors.

2. Proposed changes

At the heart of our recommendations is the belief that decision-making regarding resource allocation must be made more democratic. Besides the inherent value of democracy, there are two driving forces underlying the need for democratization. First, it is essential to protect the health care system from the threat of Thatcherism and other reactionary tendencies. Second, it is the only politically viable way to address the

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, Gord Guyatt, Andy Oxman, Ulli Diemer.

Production by AlterLinks, (416) 537-5877.

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.

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:

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

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resource allocation decisions confronting the Minister as a result of the financial crisis that is consuming the attention of the NDP government.

2.1 Levels of decision-making

Decision-making regarding the allocation of health care resources occurs at many levels, ranging from the federal government to individual health care providers and patients. Our recommendations focus on three levels of decision-making: centralized decision-making within the province, decision-making by District Health Councils and by Hospital Boards. We will make specific, practical recommendations for action at each of these levels in the final section of this statement.

2.2 Basic principles

Decisions regarding resource allocation should be guided by basic principles, including those laid out in the Canada Health Act (public administration, comprehensive coverage, universal coverage, portability and accessibility) and the ones put forward by the MRG, as described in our previous statements (social perspective, equality, effectiveness, efficiency and re-allocation).

2.3 Common standards

Standards should be established regarding the availability of essential services. It is particularly important that standards should be developed for politically sensitive services, such as abortion, to avoid social injustices that might otherwise occur as an undesired consequence of making the health care system more democratic.

2.4 Evidence-based decisions

Decisions regarding funding for specific health care interventions, organizational policies, and health protection and promotion programs should be based on evidence of effectiveness. Interventions should be supported only if there is evidence that they work. The extent of the evidence required should be determined relative to the magnitude of the potential benefits, the risks and the costs of the intervention. Impacts on health status should be the primary measure of effectiveness. Because the potential to measure impacts on health status varies with the nature of the intervention, evaluations of effectiveness should be appropriate to the nature of the intervention. The most important and expensive existing and new interventions should be evaluated.

2.5 Explicit decision-making

The basis for decisions regarding the allocation of health care resources should be made explicit. So far as possible, decisions should be based on expected outcomes.

2.6 Open decision-making

Decisions should be made openly and background information made readily accessible to all interested parties.

2.7 Representation

Grass roots representatives should be elected to serve on key decision-making bodies. The objectives of having both consumer and provider representation are to ensure that balanced consideration is given to scientific evidence and ethical issues, that consumer and provider preferences for expected outcomes are appropriately represented, that practical problems with proposed actions will be identified and addressed, and that affected groups will perceive the decisions as credible and will cooperate in implementing them.

2.8 Accountability

All elected representatives should be subject to removal by the right of recall by their constituency.

3. Practical steps towards implementing change

The following initiatives, if acted on by the Minister, have the potential to strengthen the health care system and the political standing of the NDP government, and to move the Ministry from making reactive, ad hoc (and politically unpopular) decisions to a pro-active position, while at the same time enhancing the government's ability to make tough decisions regarding resource allocation in the current economic situation. They represent an attractive alternative to the unacceptable practice of restricting funding without taking responsibility for how (or by whom) consequent decisions about resource allocation are made within hospitals and other affected health care organizations.

3.1 The Ministry should form a Central Advisory Committee on Resource Allocation.

The primary function of this committee, in the short term, would be to provide the Minister with unbiased summaries of scientific evidence, expert advice and practical guidance regarding decisions that are of immediate concern, such as the restriction of hospital funding. This committee should be comprised of people with appropriate methodological training (in epidemiology, economics, administration, ethics and allied disciplines) as well as consumer and provider representatives.

In the long term, this committee could be responsible for developing common standards regarding the availability of services across the province, act as a resource to District Health Councils and other decentralized decision-making organizations, and help to chart the transition from a publicly funded health care system to a publicly managed health care system.

3.2 District Health Councils should be developed into true democratic forums for making decisions regarding resource allocation at a regional level.

The Minister should take immediate steps to institute pilot projects in selected regions with clear objectives, thoughtful planning and appropriate evaluation. Current efforts directed at transforming District Health Councils should be consolidated under the direction of the Minister's office, they should be made consistent with the proposal for changes outlined above, they should be given a high priority and a high profile, and they should be expedited in a timely fashion that would allow for the introduction of major changes based on the results of the pilot projects within the current term of the NDP government.

In the short term, District Health Councils should be charged with ensuring adequate regional delivery of important services in the face of restricted funding. They should be provided with explicit guidelines and consultative support for doing this through the Central Advisory Committee on Resource Allocation.

3.3 Hospital Boards should be democratized.

Revision of the Hospital Act should be pushed forward and a central element of the revision should be to change the character of Hospital Boards in a way that is consistent with the proposal for changes above. Hospital Boards could then be appropriately charged with making decisions regarding resource allocation. As with the District Health

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Resource Allocation *from page 3*

Councils, the Minister should initiate pilot projects directed at democratizing Hospital Boards and, in the short term, Hospital Boards should be provided with explicit guidelines and consultative support for making decisions about resource allocation through the Central Advisory Committee on Resource Allocation.

3.4 The Minister should take steps to ensure proper representation of consumers at each level of decision-making.

One bold initiative that the Minister should consider is to facilitate an initiative to develop a Consumers' Organization for OHIP. Such an organization could be created, for example, by giving one vote to each adult member of OHIP. OHIP members could be given the option of contributing one dollar (out of OHIP's funds) to the Consumers' Organization each year. This would provide a solid financial basis for the organization. In addition OHIP could fund a newsletter that would be sent to all members, say, twice each year. The newsletter would be under the editorial control of the Consumers' Organization and would serve to educate health care consumers in Ontario, as well as providing a forum for health care consumers. The mandate of the Consumers' Organization would be to provide appropriate mechanisms for electing representatives to decision-making bodies (and holding them accountable), and to help ensure that the public is properly informed about the health care system and decisions regarding resource allocation ranging from the level of the individual to the federal government. The initiative for such an organization would have to come from consumers. There are signs of increasing activism in the labour movement around health care issues. This energy could be harnessed into providing the impetus for the Consumers' organization we are suggesting.

Prepared by tmembers of he MRG Resource Allocation Working Group, including Murray Enkin, Gord Guyatt, Haresh Kirpalani, Andy Oxman, Rosana Pellizzari, Mimi Divinsky

MRG comments on policy statements by Health Minister

Subsequent to meeting with Health Minister Frances Lankin, the MRG Steering Committee was invited to comment on recent policy statements by the Minister. The Steering Committee took the Minister up on this offer, and prepared comments on six recent policy statements. Those comments appear below:

DOCUMENT ONE:

Statement re: Consent to Treatment Act

In general, we applaud the government's proposed legislation concerning consent, advocacy, and substitute decision-making. The principle of empowering the individual regarding decisions about their own health care is one we strongly endorse. Advance directives have the potential for making a positive contribution to health care in Ontario.

We do have some concerns that the legislation not be misinterpreted. While we strongly support the right of patients to be fully informed, physicians are obliged not to provide treatments that are useless or harmful – even if patients want them. It is appropriate that physicians treat someone who wishes to commit suicide even if that person would refuse treatment at that time if given the opportunity. While we value autonomy, it is important to balance this with beneficence, non-malfeasance and justice – other ethical principles that are equally important. This is not an argument for paternalism, which we oppose, but a concern that we not lose sight of other ethical values that are sometimes in conflict with autonomy.

We believe the only major danger in the legislation is the excessive bureaucracy that could result. We believe that the interests of both patients and the system will be best served without external third parties overseeing the interactions between physicians and patients. Any potential breaches of patients' right to the care they want could be handled by existing mechanisms. The creation of a formal independent tribunal would be, we believe, a mistake. Well-meaning third-party intrusions into clinical care have often proved costly mistakes, and there is a risk that this will be another such example.

A smaller but important point is the regulation that substitute decision-makers cannot give consent for clinical research. This flies in the face of both current practice (for example in critically ill patients in intensive care units) and the ultimate interests of the populace. If an empowered institutional review board has decided that a protocol does not put a patient at risk, and the patient's advocate believes the patient, if competent, would have participated in the research, consent should be considered to be given. Without this provision research which will ultimately lead to better care for the incompetent will be stymied. Progress in care requires the conduct of carefully considered ethical research and legislation should not obstruct that research.

We have another comment that does not relate specifically to the legislation, but that we believe is important. Not only must individual members of the public be fully informed and decide whether to accept or reject a health service but the public as a group needs a mechanism to determine what constitutes a health service. In vitro fertilization is an example of a service which may or may not be seen to fall within the traditional health care system. The government may appropriately review coverage of such services. Such review must occur in the context of full public scrutiny, and full public debate.

DOCUMENT TWO:

Speech re: Regulated Health Professions Act

We applaud the amendments to the Regulated Health Professions Act. In particular we believe that involvement of substantial public representation on professions' councils is a very positive step. Choice of public representatives should be conducted in as democratic a manner as possible, with maximal public scrutiny of the conduct of public representatives.

We also note that the amendments demonstrate the government's sensitivity to the concerns of aboriginal peoples and the concerns of people in counselling roles throughout the society. Concern about sexual abuse of patients is also highly appropriate.

DOCUMENT THREE:

Remarks at the OHA Annual Meeting

The Minister is seriously and productively considering ways in which the OHA and Ministry can work together to improve hospital care. We raise our concerns about transfer of resources from hospital to community at other points in this document. The role of experts in helping to determine optimal efficiency is acknowledged in this document. Enroling experts in determining how increased efficiency can be obtained will require more than literature reviews. Our proposal regarding planning of services for hospitals is attached.

DOCUMENT FOUR:

Remarks to Action Centre '91

There is much in the specific proposals in this document that the MRG supports. Specifically, a strong leadership role for the DHCs is potentially an effective mechanism for helping to ensure efficient allocation of resources within the health care system. That role will be facilitated by adequate resources for the function of the DHCs and by the Minister's giving the message that the DHCs' place in the system should be respected by the various players. Beyond saying that the DHCs should be respected, it would seem essential to take actions that will ensure their playing a more important role by actually giving them decision-making powers rather than keeping them in an advisory capacity.

We agree that effective mechanisms for planning must be in place. It is essential that the Ministry ensures that there are adequate resources to provide logistical and methodological support. It is also important to recognize that it would be inefficient for each DHC to replicate tasks like reviewing the evidence for common decisions. The province should be taking responsibility for coordinating this. Once again, the specific proposals in the attached MRG document on planning rational allocation of resources are relevant to these issues.

We are also glad that the Minister realizes the ways in which DHCs are currently unrepresentative and not appropriately accountable to their communities. This problem must be addressed before the goals which the Minister has set for the DHCs can be achieved.

There is a tone in the document, and in specific statements, which we believe is very dangerous. It is true that at the largest level the most fundamental determinants of health are not within the health care system. The huge differences in health status between developed and less-developed countries, for instance, are largely determined by nutrition, housing, and sanitation. Within our society, however, health care makes an enormous contribution to health. There is a tremendous variety of interventions which prolong life, and even more that improve its quality. The public knows this, and attempts to persuade them otherwise will lead to loss of credibility.

It is not evident from research that community-based services will be more efficient in providing care than are hospital services. If any efficiency can be gained by shifting the burden of care for the elderly from the health care system to the community the price will be steep. There is considerable evidence that the burden of such care falls on the daughters and daughters-in-law of the frail elderly. We doubt that the government, clearly committed to dealing with women's issues, would want this to happen.

A more appropriate emphasis would be on limiting expenditures that provide no benefit while ensuring that beneficial services are maintained. We predict that if the Minister continues to portray the choices as being between health and other social services, and between hospital and community health services, the results will be disastrous. The current economic climate will not permit increases in resource expenditure in social services; we will see nothing but cuts in health. The crisis in government resources will not permit adequate increases in spending in community care; we will see nothing but inadequate hospital services. Patients will suffer. Before long, we will see unacceptable queues for clinically beneficial services. At that point, the pressures for an alternative health care delivery system will be irresistible. Two-tiered care will be reintroduced. It will become politically increasingly expedient for the government to let the public system (which serves the segments of society that tend to be politically less powerful) deteriorate further.

DOCUMENT FIVE:

Statement re: "A Renewed Health Partnership," A Report to the House on the provincial/territorial health ministers conference in Winnipeg

Our reply is directed at the Minister's comments regarding research and its application. We strongly support a national strategy to support research into innovative and cost-effective ways of delivering high-quality health care. We similarly support a central role for the federal government in assessing new medical technologies. Regulation of new technologies should be greatly increased, and should follow the model of the assessment of pharmaceutical products.

While it is desirable to call on the federal government to support research, the province must also do its share. Three specific suggestions would be to raise the percent of health care spending going into research and development, to identify research priorities and target funding, and for the province to take a leadership role in cooperating with other provinces in coordinating research initiatives. A major focus of research efforts should be on strategies for translating research into policies and practice.

Such initiatives will come to naught if the results of research are ignored. It is of little use demonstrating that medical interventions are beneficial if the resources required to intervene are cut. The Ministry appears to be ignoring research that suggests that in many instances community care may be less efficient than hospital care. As important as conducting research is, ensuring the results provides the basis for public policy.

DOCUMENT SIX:

Statement re: Ratification of OMA Contract

While we strongly support cooperation between the OMA and the MOH, the Joint Management Committee has been problematic in terms of clearly delineating the scope of its responsibilities. Even the name suggests much broader responsibilities than it is, presumably, intended to – or should – have. It is equally important to involve other organizations, including those representing nurses and other health care workers, and consumer groups. Without

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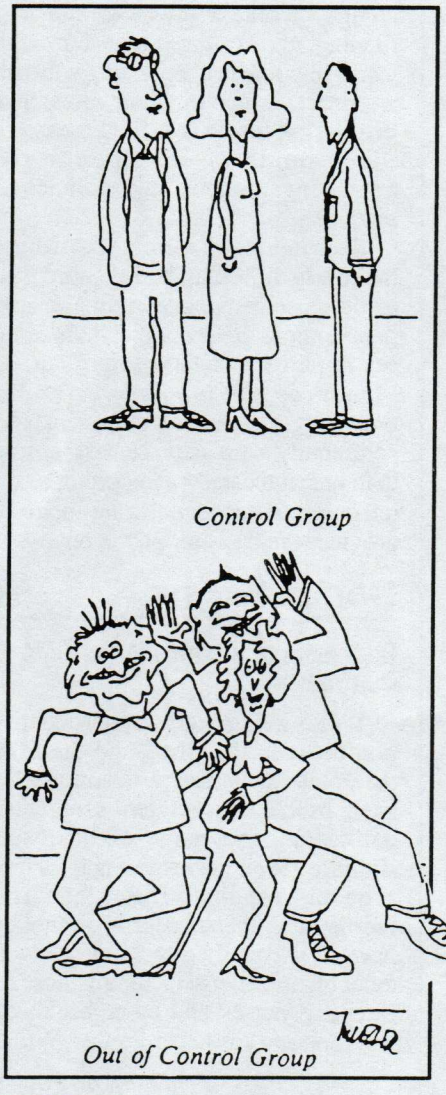
Comments, *Continued From Page*

this, the Joint Management Committee appears to give disproportionate power to the OMA and perpetuate inequalities among health care workers. Also, it is important that the Minister not allow the Joint Management Committee to become an instrument with which the OMA can obstruct positive changes in the health care system.

3) Planning rational allocation of resources

The MRG steering committee has drafted a document outlining how we believe rational planning could best be conducted. The document (see page 2) was sent to the Minister's office along with a letter containing the above comments.

Prepared by Gordon Guyatt for the Medical Reform Group Steering Committee



Control Group

Out of Control Group

Orser Commission Report looks at health planning in South Western Ontario

The Comprehensive Health System Planning Commission (also known as the Orser Commission) was founded in 1990 by the previous Minister of Health, Elinor Caplan. Its mandate was to 'develop a practical strategic plan to the year 2001 that identifies priorities for the total health care system for the southwest region so that health care resources can be allocated and managed effectively and the health status of the population in the area can be enhanced'. I understand it sprang from concerns about high per capita health care expenditures in the area and specific concerns about 'cross-border health care shopping'.

The Commission was chaired by Earl Orser, a business man in the insurance industry from London, Ontario. Nine other members included the Medical Officer of Health from Elgin-St. Thomas, as well as a family physician, a specialist and a representative from UWO. Elsabeth Jensen, the nurse manager who spoke at the April 1991 MRG meeting mentioned some aspects of the commission (*see Medical Reform Volume 11, Number 3, page 13*). She was not named as a member of the commission but I think she was on one of many working groups. I'm not sure other than the Chair, that the 'community-at-large' or the District Health Councils were included.

Southwest Ontario includes London as the main tertiary care/academic centre, Windsor, Sarnia as well as rural areas along Lake Erie and Lake Huron up to Kincardine.

Conclusions of the preliminary report include:

♦ Regional and area systems of governance can allocate resources more productively, efficiently and more responsively to community needs, than existing structures; health needs can be met within the region and health care expenditures could be contained to three percent without inflation (the estimated annual growth of the GDP).

♦ Regional and area Boards are to be 'appointed' to include representatives from the public, local government and service providers.

♦ Shifts to health promotion and disease preventions, home-based care and progress to care 'closer to home' can be achieved.

♦ A ten year capital program of $550 million is required for developing and upgrading acute and long-term care facilities.

♦ The Ministry of Health will maintain its exiting responsibilities for establishing overall policies, standards and guidelines as well as being encouraged to improve inter-ministerial health related services and develop policy.

I think this report is a good step in the direction of locally responsive health care planning with fiscal responsibility for resources decisions. South West may be too large for true community ownership but the six areas may reach that objective. South West is probably big enough to provide nearly a complete range of services to its communities. I am, of course, in support of increased attention to health promotion and disease prevention but the actual re-allocation of resources is a very difficult challenge.

What's missing in the report from my perspective is:

The total funding envelope for South West Ontario is not stated nor is the formula for calculating this stated. The annual growth in funding is based on an expected growth in GDP but what happens if the GDP doesn't grow? Is it the best marker for increased health needs?

Clear representation and accountability of the diverse South West communities on the regional and area management boards is not guaranteed through the appointment process.

Community priority setting process is not described and was not used by the commission to reach the preliminary report. Although open meetings were held in the development of the report and community 'round table' meetings were planned for comments on the report prior

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Midwifery in Ontario

A self-governing midwifery profession in Ontario will soon be a reality. In November, 1991, the Regulated Health Professions Act, 1991 and its associated bills, including the Midwifery Act, 1991, received Third Reading and Royal Assent. Proclamation is expected later this year and midwives will be able to be registered shortly thereafter. Under this legislation, midwives have entitlement to assessment, monitoring and provision of care to well women and to their newborn infants. As well, the statute provides for the creation of a College of Midwives to be the registering and governing body.

The legal scope of practice of midwives includes usual prenatal care activities, managing labour, conducting spontaneous births, performing amniotomies, cutting and repairing episiotomies, prescribing from a specified list of medications, assessing the newborn and providing counselling and teaching throughout the childbearing cycle. In addition, midwives must recognize situations that require consultation with or transferral of care to a physician. Protocols listing such situations have been drafted by the Interim Regulatory Council on Midwifery (a council appointed to set standards and procedures for the future College of Midwives) and are being reviewed by medical and nursing organizations. The protocols help define some of the boundaries of midwifery practice. For example, during the antenatal period inappropriate uterine growth requires a consultation, whereas frank vaginal bleeding requires a transfer of care.

These expectations make it clear that there must be effective working relationships between midwives and physicians. Local circumstances will influence who will be first contacted: a family doctor, an obstetrician or other specialist. While the specific arrangements for each practice situation will be resolved gradually as practitioners become registered, the protocols are flexible enough to be used across the province. It should not be necessary for individual hospitals, clinics, health centres, etc. to list numerous additional consultation or transfer requirements over and above those issued by the College of Midwives. The continuing discussions between midwifery organizations and other professions are useful in anticipating potentially conflictual situations and resolving them, when possible, before enactment of the new law.

Referral relationships will be enhanced by resolving questions about medico-legal liability. The Interim Regulatory Council and practising midwives support independent liability insurance for midwives. Discussions with insurers are underway and will continue throughout the following months as a key aspect of establishing legalized practice.

Midwives will establish practices in a variety of ways. Some may form group practices, rotating on-call and office time for their clientele. This kind of group practice could be based in a community office, a hospital out-patient facility, or possibly in the future, a free-standing birth centre. Other midwives may work as members of a larger multidisciplinary team in a community health centre or in a comprehensive health organization. It is possible that a midwife could join a medical group practice and have responsibility for pregnant women who are at no identifiable risk. Midwives will not be paid on a fee-for-service basis, but the final decisions about method(s) of payment must yet be made.

An essential feature of any model of practice that is created is continuity of care throughout pregnancy, labour, birth and the puerperium. This will usually be accomplished by having only two or three midwives participate in the care of any one client. Clients can then feel assured that their individual concerns and choices are well known to the persons attending them. Continuity of care is dependent on midwives having access to community and hospital facilities so that midwifery care can be provided across a spectrum of locations. Prenatal visits may be in a clinic, office or, on occasion, in the woman's home. Likewise, birth may occur in hospital, special birth centres or at home. Most postnatal care will be at home since early hospital discharge after a normal birth is now frequent.

In order for continuity of care to be achievable, midwives hope there will be changes to The Public Hospitals Act which will permit them to directly admit women in normal spontaneous labour at term and to discharge mother and baby after a normal birth. The Public Hospitals Act is under review within the Ministry of Health, but the timetable for new legislative proposals is not set. The relationship of midwives to hospitals is a focus of continued work.

When the proposed midwifery act is proclaimed, the first persons to be considered for registration will be experienced current practitioners. A one-time formal educational opportunity will be available in October, 1992 at the Michener Institute for Applied Health Sciences (Toronto). Suzanne Houd, an experienced Danish midwife who is familiar with the development of midwifery in Ontario and has consulted extensively for the World Health Organization, has agreed to come to Ontario for at least a year to head the program. She will be responsible for designing methods that will assess the knowledge, skills and clinical judgment of current practitioners. Those who demonstrate competence in antepartum,

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Fran Scott

Fran Scott is an MRG member who is currently the Medical Officer of Health for Hamilton-Wentworth

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to final submission, it is not clear how continued community input will be facilitated.

There is no clear role for existing DHCs.

The draft report was presented to the Minister in September 1991 and made public. Following response from the community the final report was presented to Health Minister Frances Lankin in December 1991. This final report has not yet been made public but is said to be quite similar to the interim report.

The Minister has expressed a lot of interest and encouragement about this report in public meetings.

If anyone is interested in reading the executive summary of the interim report, Ulli Diemer has a copy. Once the final report is made public it will be interesting to discuss it further.

Midwifery *from Page Seven*

intrapartum, postpartum and newborn care will then be eligible for registration by the College of Midwives. This special program will operate for up to one year following proclamation of the legislation. Actual completion time for each person will be individual; it is possible that some persons will complete all requirements in a period of two to three months and qualify for registration.

The government announced on October 15, 1991 that a baccalaureate degree program to prepare future midwives will be created. The call for proposals went to degree granting institutions with health sciences programs. An educational institution is expected to be chosen during 1992 and the first students to be admitted by the 1993/94 academic year.

While considerable work remains to be done before regulated midwifery practices are in place, the planning process is well underway. The Association of Ontario Midwives and the Interim Regulatory Council on Midwifery are working in close co-operation to devise the standards and registration requirements. They have consulted with medical and nursing organizations and will continue doing so in order to promote the integration of midwifery into Ontario's health-care system. Questions about the introduction of midwifery can be addressed to the Interim Regulatory Council or the professional association (see below).

Association of Ontario Midwives
President: Ms Bobbi Soderstrom
P.O. Box 85, Station C
Toronto, Ontario M6J 3M7

Interim Regulatory Council on Midwifery
Chair: Ms Mary Eberts
Administrative Officer: Ms Holly Nimmons
P. O. Box 2213, Station P, Suite 285
Toronto, Ontario M5S 2T2

[Portions of this article were published in "The Implementation of Midwifery in Ontario," Ontario Medical Review, 58(11)9-12, 1991.]

Karyn J Kaufman RN, Cnm, Drph
Karyn J. Kaufman is an Associate Professor in the Faculty of Health Sciences at McMaster University

OHIP

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advance so they can be published in *Medical Reform* prior to the Spring meetings).

To help initiate consideration of this issue, here are some of the observations and points of view expressed at the Steering Committee meetings:

A definition of "cosmetic" procedures which includes sex reassignment surgery, sterilization, in vitro fertilization, and psychoanalysis is interesting, to say the least.

Current MRG policies do not really deal with cosmetic procedures. There is a policy support ing effective procedures, but where do we stand on effective cosmetic procedures? Should these be insured under OHIP?

One point of view expressed was that the proposed delistings are a serious threat to medicare. Although these procedures have been described as "cosmetic", there are appropriate medical indications for each and every one. De-insuring these procedures would mean a two-tiered system, in which those who can afford to pay for them would have access, while those who could not afford to pay would be denied access. The MRG should continue to support OHIP coverage for all treatments of proven medical benefit, those which improve the quality of life as well as those which prolong it.

It was also argued that it is a fallacy to suppose that delisting treatments such as psychoanalysis would save OHIP money. What would happen would be that psychiatrists, for example, would see other patients in the time they would have spent doing psychoanalysis. They would continue to work the same number of hours as before, and would continue to bill OHIP as much as before.

Another point of view was that there *should* be a two-tiered system for procedures which are not medically necessary. In-vitro fertilization is an example: a personal choice rather than a medical necessity. The fact something is done by a doctor does not necessarily mean it is medically necessary. Many things which contribute to physical or emotional well-being are not medical and are not funded ut of medicare: for example, housing, food, vacations. There was agreement that we need to define medical need

A position which emerged out of the Steering Committee discussion was that at least some of the procedures on the list above should go on a 'restricted' list. They should be performed if there is an established need for them, but they should be justified on a case-by-base basis, rather than permitting any physician to do them whenever s/he wants to with no questions asked. There should be a tracking system in place for these procedures, and physician billings for them should be monitored. It was also suggested that an administrative system be put in place which would be similar to the steps required to prescribe a non-approved drug. The physician would be required to fill out a form in order to do a procedure on the restricted list. There should be a definition of what is medically necessary to guide physician discretion.

There was discussion of what criteria should be put in place to determine when such procedures should be done on an insured basis. Suggested criteria included assessment of effectiveness and adequate evidence of patient benefit, based on humane consideration of need. Procedures not of proven effectiveness should not be funded. Procedures which are proven to reduce morbidity should be funded. Injuries should be treated. Procedures to correct major disfigurement should be funded.

At the same time, there was concern that a case-by-case approach would pose problems. Physicians who specialize in a particular procedure will always tend to see it as highly beneficial and medically necessary. Patient benefit can be difficult to define: people who get these procedures tend to feel better for having them done. It was suggested that providers of these services should be audited, since the problem of over-utilization often originates with the providers, not the patients.

Procedural questions were also raised. Would there be any avenue of appeal if a request to do a procedure was turned down? One response was that no matter where you draw the line, there will always be borderline cases. If someone wants the procedure badly enough even though it is not judged medically necessary, they will have to pay for it.

If you have comments, send them, on paper or IBM-compatible computer disk, to Medical Reform, Box 366, Stn J, Toronto M4J 4Y8. You can fax your comments to (416) 588-9167, but because this is a voice as well as a fax line, it is necessary to first confirm that the fax is on. (If the answering machine comes on, press the Start button on your fax and the machine will automatically switch to fax mode. If a human answers, tell him you want to send a fax.)

Organizational changes in the Ministry of Health

MRG Steering Committee member Murray Enkin was interviewed on radio station CKWW in Windsor regarding organizational changes in the Ministry of Health announced by Deputy Minister Michael Dekter. The organizational changes, and Murray's comments on them, appear below:

New divisions within Ministry

1. To oversee programs traditionally associated with health care: hospitals, OHIP, drugs

2. Health promotion and disease prevention

3. Policy shift to preventive care, from hospital- and illness-based systems to community and disease prevention

4. To oversee other segments.

MRG response:

Support for the principles, but caution of the dangers.

1. Agree that all health programs require supervision, and that attention be paid to encouragement of effective, efficient care, with careful attention to evidence of efficacy in improving health.

- We should limit expenses that provide no benefit, while ensuring that beneficial services are maintained.
- If hospital care is excessively cut, we will develop excessively long queues, to the extent that they will not be acceptable to the middle classes. Pressure will then develop to a two tier system of care, and the public service will further deteriorate, because the pressure from the middle and wealthier classes will be taken off.
- Practice guidelines based on evidence of effectiveness - e.g. task force on periodic health examinations, task force on Caesarean section, appropriate use of diagnostic and laboratory tests

2. Government has an important role to play in health promotion and disease prevention.

- Must not forget that, while it is true that over all, oth er factors, such as housing, nutrition, life style are more important determinants of health than traditional health care is, within our society health care makes a very important contribution to prolonging life, and at times to improving quality of life.

3. Although the principle of shift from illness based systems to preventive care in community is superficially very attractive, we see potential for real dangers in it.

- In present economic situation, there is a real danger that "transferring resources to community" may simply be a euphemism for cutting funding of hospitals. Money for improved community services might just not be available. (Example: psychiatric services)
- No evidence that community care is more efficient
- danger that in shifting care from institution to community, we are often simply transferring care to the daughters and daughter-in-laws of the elderly.

Principles

1. Allocation – Decisions about allocation of health care resources must be viewed within the context of how society allocates its resources in general – not just health and social services as two competing compartments.

2. Equality – of all , to both healthy environment and access to health care

3. Effectiveness – support only if evidence that they improve quality or length of life.

4. Efficiency – maximum benefits from resources expended

5. Reallocation – from non-health or social services related (in broad sense of term) towards improvement of health

Murray Enkin
Murray Enkin is a member of the MRG Steering Committee

Patients without health cards refused service

There were several media reports recently of parents being refused medical treatment for their children because they didn't have health cards. In one incident last August, a four-month infant was turned away by three different clinics in the week before his death because he did not yet have a health card.

The MRG was asked to comment on these incidents by several newspapers and radio and TV stations. In those interviews, MRG spokesperson Gord Guyatt made the following points:

1) No one – whether an adult or a child – should be refused medical care, card or no card.

2) Physicians who refuse care are behaving in an unethical manner.

3) Without seeing a patient first, it is impossible to know whether a case is urgent.

4) The Ministry must ensure physicians get reimbursed for their services.

5) This problem is likely to increase after the March 1 deadline. Physicians should respond by delivering service to individuals without a card, then aiding them in obtaining a card. Physicians who deal with large dispossessed populations (where illiteracy rates are high and social skills are low) may be faced with excessive numbers of such individuals. The provincial government must take the initiative to ensure that only a small number of people have to be signed up by their physicians.

6) The people of Ontario should make sure this situation is stopped and doesn't recur.

Efficiency and Resource Allocation

Review of: Outcomes research, cost containment, and the fear of health care rationing. Wennberg JE. N Engl J Med 1990;323:1202-1204.

This paper was published late in 1990. It is the oldest paper I had it in my file of New England Journal of Medicine articles which could be of interest to MRG members. I chose to review the paper, rather than a more current one, because I believe the issues it addresses are so important, and the concepts so crucial to most health care issues we currently face.

Wennberg is a brilliant New England academic researcher who has made a major impact on thinking regarding health resource allocation through his work in small area analysis of medical procedures and use of medical resources. Basically, this research looks at differences in health care use across areas which are both geographically close and sociodemographically similar. Logically, one would think that utilization of medical procedures and medical resources should be very similar across such areas.

It turns out that this is not the case. Wennberg has shown, for instance, that Bostonians use about 4.5 hospital beds per 1,000 members of the population, in comparison with fewer than 3 beds per 1,000 in nearby New Haven. One must conclude from this that hospital services are either being rationed in New Haven or over-utilized in Boston.

Findings about small area variation in health resource utilization have spawned a movement known as health outcomes research. The idea is to find out what health care interventions actually improve outcomes and which do not. In this "sounding board" piece in the New England Journal, Wennberg reviewed some of his thoughts about outcomes research.

The way outcomes research is being implemented involves examining different patterns of medical practice and looking at the outcomes of patients treated in different ways. This process, unless done in the context of randomized trials, has its dangers. Unless one is sure, for instance, that Bostonians are not poorer and/or sicker than those in New Haven, one would be reluctant to conclude they are over-utilizing hospital services, even if they are no healthier. Nevertheless, important information, if only to generate hypotheses and provide initial guidelines for practice, is likely to come from the outcomes research movement.

Wennberg feels strongly that patients will choose very different health care options depending on their preferences. He cites his own work in men with benign prostatic hypertrophy. He has found that men differ in their degree of concern about symptoms. "Even some severely symptomatic patients are not bothered very much by their condition and prefer watchful waiting to surgery." He argues that practice guidelines (coming from outcomes research, or from other sorts of information) must take patient preferences into account.

Wennberg then turns to the big question of whether we are currently spending more in health care than we need to deliver all fully beneficial services, or whether we have reached the point at which beneficial services need to be rationed. He argues the former position. He provides two reasons. First, he suggest that current rates of use of invasive, high-technology medicine could well be higher than patients want because patients are more averse to risks than are physicians. The second reason is the possibility that we have over-invested in the use of hospitals for the treatment of patients with medical conditions for which there is high variation in use.

Most of us would like to believe that this is the case. To what extent is apparent hospital-bed utilization in Canada due to long-stay patients in whom the problems are primarily social? To what extent do we want to turn care of such people back to their families (and, given current social organization, to their daughters and daughters-in-law)? But it is not particularly reassuring that the example given by Wennberg of use of hospital resources for unproven medical interventions — alcohol and drug rehabilitation programs — have since been shown in randomized trials to improve patient outcomes.

Finally, Wennberg asks readers to make the assumption that within three or four years outcomes research identifies many inefficiencies in the current deployment of resources. He asks whether, under these circumstances, we can expect that the pressures placed on the doctor-patient relationship by managed care and practice guidelines will result in decreasing inefficiencies to the point of major resource saving.

He thinks not. "Everything I have learned about the peculiar relations among medical theory, the supply of resources, and the practice styles of physicians in fee-for-service markets warns me that this cannot be so." As an alternative, he suggests the Canadian model in which policies deal directly with the capacity of the system. Reduction in hospitalizations should be achieved, for example, with reduction in the number of hospital beds. Reduction in use of physicians should be achieved by reducing the number of physicians.

The issues addressed by Wennberg are very much those that have been dealt with by the MRG's resource allocation group. Our conclusions were presented in the last issue of *Medical Reform* in the form of the background document for our recent meeting with the Minister of Health. Essentially, we feel that management must (at least in part) be at the systems level, and the management must be guided by both the evidence and by input from the community — that is, a decision-making process that is open to scrutiny, more democratic and consistent with the available data. MRG input into maintaining high-quality universal care in an era of fiscal constraint will require continued review of accumulating evidence, and of the political realities.

Gord Guyatt

Administrative costs in health care in Canada and the USA

Review of: The deteriorating administrative efficiency of the U.S. Health Care system. Woolhandler S, Himmelstein DU. N Engl J Med 1991;324:1243-8.

The news in this article is simple, and not particularly startling. In 1983 these same authors demonstrated that administrative costs in the American health care system were far greater than in the Canadian system, and the British system was cheaper yet. In this latest paper they review data to 1987 and show that in four years the Canadian system has, overall, become more efficient. At the same time, the American system has become far less efficient.

The bottom line figures are stark. Americans pay insurance overhead of 0.61% versus 0.11% of GNP, hospital administration of 0.93% versus 0.32%, and overall administrative costs of 2.3% versus 0.76% of the GNP. The amount of the difference is such that if, overnight, the U.S. switched to a Canadian style system and achieved the potential costs savings they could fund all their uninsured and under-insured without spending an extra dollar on health care.

The reasons for the difference in administrative costs are clear. In Canada there are a total of 10 administrative bodies — one in each province. These are charged with all the paperwork associated with health insurance in the province — and that is their sole responsibility. In the United States there are literally hundreds of insurers. Thus, one disadvantage for the US system is that economies of scale are lost. The existence of numerous insurers necessitates determinations of eligibility that are superfluous under a single, comprehensive program.

The waste of the American system extends into the hospitals. American hospitals require a sophisticated billing department with an extensive internal accounting structure that is necessary to attribute all costs and charges to individual patients and physicians. This is unnecessary in Canadian hospitals.

My real motivation for reviewing this paper was so that I could quote passages at some length. Himmelstein in particular writes with a compelling irony. I found the following passages particularly delicious.

"Medicine is increasingly a spectator sport. Doctors, patients, and nurses perform before an enlarging audience of utilization reviewers, efficiency experts, and cost managers. A cynic viewing the uninflected curve of rising health care spending might wonder whether the cost-containment experts cost more than they contain; one is reminded of the Chinese proverb "There is no use going to bed early to save candles if the result is twins."

"The recent quest for efficiency has apparently amplified inefficiency. Cost-containment programs predicated on stringent scrutiny of the clinical encounter have required an army of bureaucrats to eliminate modest mounts of unnecessary care. Each piece of medical terrain is meticulously inspected except that beneath the inspectors' feet. Paradoxically, the cost-management industry is among the fastest-growing segments of the health care economy and is expected to generate $7 billion in revenues by 1993... In contrast, Canada has evolved simple mechanisms to enforce an overall budget, but it allows doctors and patients wide latitude in deciding how the funds are spent."

Woolhandler and Himmelstein are among the leaders in the American movement for a universal single-payer system. They have been instrumental in the formation and development of the increasingly effective Physicians for a National Health Plan which strongly advocates a Canadian-style system. They have repeatedly called on the MRG to provide speakers for public and physicians' meetings to mobilize support for American health care reform. Working with them has been an instructive and exciting for the MRG.

Gord Guyatt

Physician Wanted

The City of York requires a physician to work part-time in our Birth Control and Sexually Transmitted Disease clinic at Jane and St. Clair.

The physician is to commence on May 12, 1992 and the hours are Tuesdays from 3:30 p.m. to 8:30 p.m.

Previous experience in family planning and/or sexually transmitted diseases is an asset. Interest in adolescent health care is required.

Please call:
Donalda McCabe
Supervisor, Sexual Health Program
City of York Health Unit
662 Jane Street
City of York, Ontario
M6N 4A7
(416) 394-2808.

Physicians required

As we went to press we received information about two committees which need physicians to serve on them.

A physician from Northern Ontario is being sought to serve on a committee which meets approximately one day per month to rule on disputed OHIP claims. Travel costs are paid and the fee is $436 per diem.

The other position involves serving on an appeal board to hear appeals from physicians who have been denied hospital privileges. This body meets five days per month; it is suggested that a retired physician might wish to serve on such a committee.

Full information is available through the MRG office, (416) 588-9167.

News Briefs

Health Ministry re-structured

The government announced a series of organizational changes in the Ministry of Health on January 20. The existing five divisions in the Ministry are being replaced by four new management groups. They are the Health System Management Group (covering programs associated with hospitals, payments to doctors, drug programs, and laboratory services); the Population Health and Community Services System Group (covering health promotion, disease prevention, and community services); the Health Strategies Group (to create policies and plans to shift toward preventive and community care and away from hospital and illness-based systems, and to oversee negotiations with the OMA and other contract negotiations); and the Corporate Management and Support Group (to provide administrative support to the other three management groups.

New Ministry strategies

Health Minister Frances Lankin announced a set of strategies and initiatives which she said were to guide the Ministry over the next three to five years. The stated aim is to "shift our view of health away from its emphasis on treatment to a wider vision that includes communities, living standards, and the personal choices that people make", while simultaneously creating a system "in which costs will be brought under tighter control." The Ministry has adopted five health goals articulated by the Premier's Council on Health Strategy as the basic of its approach. The goals are: 1) Shift emphasis from treatment to health promotion and disease prevention; 2) Foster strong supportive families and communities; 3) Ensure a safe, high quality physical environment; 4) Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death; 5) Provide accessible, affordable health services for all. Specific initiatives will include three major program reviews, of hospitals, drugs, and laboratory services. Lankin said that the Ministry also intends to implement the redirection in long-term care with a new emphasis on community-based programs and services.

Hospitals get 1% increase

Ontario's hospitals have been told that they, like universities and colleges and other recipients of provincial funding, will be held to a one per cent funding increase for 1992-93, and increases of two per cent for each of the following two years. The government suggested that hospitals should achieve greater efficiency by better use of existing services; encouraging the shift from inpatient to outpatient care; better links between hospitals and with community agencies; elimination of duplication; and better local and regional planning.

Health ministers adopt strategy on MD numbers

In a January meeting, provincial and territorial health ministers adopted a common strategy on 'physician resource management'. Measures include setting up a national co-ordinating committee on postgraduate medical training; reducing enrollment in medical schools by 10% starting in 1993; reducing postgraduate medical training positions by 10%; reducing the recruitment of visa trainee graduates of foreign medical schools; supporting the development of national clinical guidelines with emphasis on health outcome research; replacing fee-for-service "wherever that method of payment aligns poorly with the nature or objective of the services being provided"; increased utilization of alternative service delivery models; restructuring and rationalizing the funding of academic medical centres; introducing initiatives to improve access to clinical services in rural communities.

Medical schools disagree

Medical school administrators are saying that cutting back on admissions is the wrong way to curb health care costs. According to John Provan, associate dean of medicine at the University of Toronto, the association of medical schools is forecasting a shortage of physicians by the end of the decade. The projections are based on factors such as an aging and growing population, and on the tendency for doctors to reduce their hours of work. There are currently about 1,755 first-year students enrolled in Canadian medical schools. According to Provan, the proposal to cut post-graduate positions by 10% would be especially problematic.

Fund for laid-off workers

The Ontario government plans to set up a fund to assist hospital workers who are laid off, Health Minister Frances Lankin has announced. Ontario Hospital Association President Dennis Timbrell has predicted that 13,000 hospital workers will lose their jobs because of government spending restraints, but Lankin disputed those figures, predicting that a maximum of 2,000 jobs would be lost.

Hospital workers laid off

Four Ontario hospitals are laying off about 200 employees in the wake of funding restrictions. Mount Sinai Hospital is Toronto is laying off 90 employees, including 51 RNAs and lab workers; Joseph Brant Memorial Hospital in Burlington is laying off 80 workers. Sudbury Memorial Hospital is laying off more than two dozen employees, most of these layoffs are classified as temporary. Sudbury General Hospital laid off four people, and said that between 75 and 115 might be laid off later.

Lab fees rolled back

Ontario Health Minister Frances Lankin has rolled back fees paid to privately owned medical laboratories by 5 per cent. This reverses a trend which saw lab fees rising by more than 15 per cent a year over the last 10 years. The money paid to the province's 173 private testing labs has been increasingly dramatically. In 1980-81, the province paid out $112 million; in 1990-91, the amount had risen to $428 million. According to Dr. Dennis Psutka, a former Ontario assistant deputy minister of health, "All the provinces have the same problem and none of them knows what to do about it. The attempts to regulate the private lab industry have all been resounding failures." A number of factors are seen as contributing to the increase. These include an increase in the number of physicians. In Ontario, the number of physicians has grown at 3 per cent a year in recent years, while the population has grown one per cent a year. Not only are there more physicians ordering tests, but physicians are ordering more tests: the number of tests per patient has been increasing at a rate of 4.5 per cent a year.

News Briefs

Health and safety centre faces closure

The federal government is developing a plan to shut down the Canadian Centre of Occupational Health and Safety (CCOHS). A confidential Treasury Board document obtained by the Canadian labour Congress instructs the federal Ministry of Labour to shut down the centre unless the provinces or the private sector want to take it over. The CCOHS collects and distributes free information on occupational health and safety matters. According to Dick Martin, a director of the centre, the CCOHS receives tens of thousands of inquires each year from business and labour. Mr. Martin said that "at a time when health costs are soaring, it is ludicrous to close a centre that exists to prevent disease and accidents. It provides life-saving information."

Patent protection extended

The federal Progressive Conservative government has announced that it will increase patent protection for multinational pharmaceutical companies to 20 years. The current system gives protection for up to 10 years. The decision was harshly criticized by Canadian generic drug companies and by consumer groups, who said that the result would be increased costs for consumers and government drug benefit plans. The average price of single-source drugs (drugs for which there was only one supplier) rose 350 per cent between 1979 and 1988. By comparison, the average price of drugs for which there was more than one supplier rose by less than 100 per cent. In the United States, where patent protection has been stronger than in Canada, prices for name-brand drugs are up to three times higher than they are in Canada.

Quebec pays more for drugs

Quebec is paying drug companies between 25 and 124 per cent more than Ontario for identical drugs, a legislative committee has learned. The price discrepancy adds about $40 million to the $500 million annual cost of the provincial drug plan. The committee was looking at ways of reducing Quebec's pharmaceutical costs, which have increased by more than double the rate of inflation for the past two decades. Claude Lafontaine, president of the Quebec Order of Pharmacists, said that costs are increasingly dramatically not because of abuse but because the province is spending too much money on drugs and not enough on pharmaceutical expertise. Mr. Lafontaine said that in the doctor-driven health care system, pharmacists have become "mere dispensers of drugs."

Toronto Hospital shifts medical priorities

The Toronto Hospital has adopted a new mission statement which narrows the hospital's focus. The new mission statements emphasizes cardiology, neurosurgery, cancer treatment, and transplants, while de-emphasizing internal medicine, women's reproductive health, and mental health. According to hospital president Dr. Alan Hudson, "The Toronto Hospital has been at world levels in a whole variety of programs. That number of programs at which we will be at world level will be reduced."

Depo-Provera

The Canadian Coalition of Depo-Provers has expressed its concern about pending approval of Depo-Provera as an injectable long-lasting contraceptive. The Coalition says that, based on the available evidence, Depo-Provera should not be released for use as a contraceptive at the present time. It calls for strict protocols to be followed when prescribing drugs for unapproved uses, stating that such protocols should include informing the patient of the drug's status, and of the concerns about long term safety; and obtaining a signed consent. The Coalition wants a mandatory reporting system in place to track the drug's use and allow for follow-up and research. The Coalition also wants the drug approval process to be made much more public and open.

Abortion clinic attacked

The Morgentaler abortion clinic in Toronto was subjected to an arson attack on January 24. A flammable substance was used to ignite the front doors. The fire caused $5,000 damage to the clinic and $2,000 damage to an adjacent building. Three people were forced to flee their apartment above a neighbourhood store.

Genital mutilation banned

The College of Physicians and Surgeons has issued a statement telling doctors not to perform so-called 'female circumcision'. The move came after some doctors reported being approached by immigrants from Africa to perform the ritual on their daughters. The College also called on the federal government to outlaw the practice, which is a traditional practice is some parts of Africa. Various forms of the practice can involve removal of the clitoris and the labia, and sewing shut of the vagina.

Anonymous AIDS testing

The Ontario Ministry of Health has selected eight municipalities to set up anonymous AIDS testing facilities.

AIDS registry to be set up

The task of setting up the federal government's AIDS information registry has been turned over to a private company, Price Waterhouse. The registry was to have been set up under the auspices of the University of Toronto, but after a series of problems and controversies, the government took the project away from the university. The registry is to feature a computerized data base containing the latest information on AIDS treatments. The data are to be available to doctors and patients across Canada, and is now scheduled to be in operation sometime this spring.

Racism charged

The Congress of Black Women of Canada has called for an inquiry into racism in Ontario's health care system. "This is a huge problem in health care facilities", said Akura Benjamin of the Toronto chapter of the Congress. The Ontario Human Rights Commission is currently conducting an inquiry into allegations of racism in promotion practices made by nine nurses at Northwestern Hospital in Toronto.

Secrecy deals under fire

Lawyers representing plaintiffs in suits against breast-implant manufacturers say they had documents at least eight years ago which showed that the manufacturers knew that the implants could be dangerous. However, because of court-approved secrecy agreements, known as protective orders, they were

prevented from making the information public. Manufacturers in the United States routinely demand secrecy agreements as a condition of settling lawsuits. As a result of the secrecy agreements, officials of the U.S. Food and Drug Administration did not learn about studies which showed the implants might be dangerous.

New Zealand protests

A series of marches and demonstrations took place in New Zealand last month to protest against the implementation of user fees and health care cutbacks. With the new measures, New Zealanders will be charged for hospital treatment for the first time in 50 years. Those on unemployment or social welfare benefits will have to present a special card to qualify for free hospital care and reduced charges for visits to primary care physicians. Low-income people who do not qualify for free hospital care will receive a partial subsidy. Those classified as "high-income" have to pay full rates. The "high-income" category includes almost half the population.

Tsongas rebutted

Democratic presidential candidate Paul Tsongas' swipes at the Canadian health care system have attracted spirited rebuttals from north of the border. Tsongas, a bone marrow transplant recipient, stated that if he had sought treatment in Canada, he might have died, because "socialized medicine" stifles life-saving research and technology. Doctors at the Ontario Cancer Institute/Princess Margaret Hospital have pointed out that the research which made Tsongas' transplant possible was in fact done in Canada, at the OCI/PMH, by Drs. Ernest McCulloch and James Till. Dr. Don Carlow, president of OCI/PMH, was quoted in *Ontario Medicine* as saying that Tsongas "was fortunate to be in a position to afford the best treatment available in the U.S. Many Americans do not have the same privilege."

What the doctor ordered

How does the thrusting hospital maximise its income in the market-style National Health Service? Simple: it gets patients to give far-off addresses, sends them to the wrong wards and discharges them before they are fit.

These and other tricks of the trade are disclosed in the latest issue of *The Health Service Journal* by an anonymous health authority director of purchasing, whose job is to scrutinize and settle hospitals' bills.

First, and most important, is to try to stop the patient giving a local address. Students, temporary workers, members of the armed forces and other should be inveigled into giving their "permanent" address, likely to be in another health district which has not contract with the hospital and can therefore be billed for extra cash.

A patient taken to the wrong department and left, even if only for a few minutes, can enable the wily hospital to send two bills. Some provider units have submitted such claims for admissions lasting less than a minute.

If possible, the director suggests, try to discharge the patient before treatment is ended: most patients will readily cooperation with a readmission shortly afterwards. "You can then charge for two admissions at average speciality costs which were, of course, based on the length of a normal admission. This will double the value of the patient at a fraction of the cost."

-David Brindle, in the Manchester Guardian Weekly, February 9, 1992

Publications Received

Their Hands in Our Safe: A critique of right-wing proposals on financing the NHS

By the Socialist Health Association

An analysis of proposals for market incentives and privatization in Britain's National Health Service.

Socialist Health Association, 195 Walworth Road, London SE17 1RP

Critical Public Health

1991 issue 4 contains articles on "Putting the Community into Community Care"; "Neighbourhoods: the local population as health care consumers, citizens or providers?"; and "The health of the nation".

Atlantic Monthly

The March 1992 issue contains an article by Arnold Relman on "What Market Values are Doing to Medicine".

Patients as Consumers or Co-Producers: An Alternative to the Market

Paper by Julian Tudor Hart

INFACT Newsletter

The lead article in the Winter 1992 issue is "Rehabilitating the Breastfeeding Environment: The Baby-Friendly Hospital Initiative".

HAI News

The February 1992 features a lead article on "Rational Drug Use: A Challenge to Medical Schools".

Socialism and Health

Quarterly, published by Socialist Health Association, 195 Walworth Road, London SE17 1RP