MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

Medical Reform Group of Ontario, P.O. Box 158, Station D, Toronto, Ontario M6P 3J8 (416) 588-9167

Volume 12, Number 5 — December 1992

MRG meeting favours capitation, salary over fee-for-service for primary care MDs

A lively discussion among the 25 participants at the Medical Reform Group's fall general meeting ended in agreement that the MRG should support and promote moves toward capitation and salary as payment mechanisms for primary-care physicians. The currently prevalent fee-for-service mechanism was seen as the least desirable of the three main payment mechanisms in most primary care settings.

The discussion arose out of suggestions from both the Resource Allocation and Primary Care Working Groups that the MRG should review its policy on payment for physicians. The current policy dates from May 1980 (*Resolutions MRG5 and MRG6*). The 1980 policy states that in light of "considerable evidence from other countries for systems of physician payment other than fee-for-service", "experimental programmes in which significant numbers of physicians would be engaged to practise on salary and capitation" be set up, with the results to be assessed after a suitable period of time. At the same meeting in 1980, the MRG also supported "the establishment of community health centres as a major method oSf primary health care delivery".

INSIDE

Twelve-and-a-half years later, MRG members came to some similar conclusions. Participants at the November 18, 1992 meeting agreed to support the following formulation.

However, it was agreed to solicit further comments and feedback from the whole MRG membership before taking further action on this position. If you have any thoughts or comments, positive, negative, or otherwise, about the following, please make them known to other MRG members through the newsletter in the form of a note, a letter, or an article. You may write to *Medical Reform*, Box 158, Station D, Toronto M6P 3J8, or fax (416) 588-3765.

This is what was agreed on at the fall general meeting:

That the Medical Reform Group supports structures of payment and primary care provision which recognize and address the social and economic roots of ill health; which are based on rational planning, accountability, and monitoring and assessment of results; which give a greater role to non-physicians; and which favour capitation and salary as payment mechanisms.

There was agreement that it is time to put this issue near the top of the agenda, because it is a crucial factor in primary care delivery, and it is clear that governments are planning to make major changes to the present system.

There was also discussion of organizing, or co-sponsoring, a conference on models of primary care delivery. *Any MRG member (or newsletter subscriber) who has ideas about what form such a conference should take, or who would like to help plan it, is asked to contact the Steering Committee by calling (416) 588-9167 or writing or faxing as indicated above.*▼

Medicare under attack: Time for a popular campaign

Let's hope that the revival of the Ontario Health Coalition and the Campaign to Save Medicare, spearheaded this past summer by the Canadian Union of Public Employees, are signs of renewed interest and commitment not only to improving health care services, but also the health status of Canadians.

Medicare in the 21st Century

A recent Winnipeg conference of the National Union of Public and General Employees brought together public sector health care workers from across the country for policy review and strategy development.

The conference opened with a keynote address from Tony Mazzochi of the U.S. Oil, Chemical and Atomic Energy Workers International Union. He cautioned participants on the potential for significant change as a result of the election of Bill Clinton. Other speakers combined to provide an analysis which reaffirmed the urgency of concerted political action. Highlights of the conference:

♦ Ginny Devine, a polling expert, talked about the results of recent surveys and focus groups – Canadians see medicare as the major distinguishing feature of the country; they are opposed to its dismantling but, unless they have recently had some personal experience with the health care system, have little idea of the erosion that has already taken place. Her presentation underlined the limited public understanding of the complexities of health care delivery.

♦ Michael Rachlis tied the absence of a progressive policy agenda on health care to the lack of a strategy for health. He linked major problem areas with a physician-directed system, and counseled attention to a democratic system reform

Continued on page 2

Medicare Under Attack
Continued from Page One

and a comprehensive labour adjustment strategy which recognized the continuing need for workers in the health sector.

♦ Patty Sullivan, Tim Sale, and Janet Maher spoke about models and priorities in a reformed delivery system, including emphasis on a holistic, community-based approach, and the need for improved equity, access and accountability. In participants identified strategies for raising the profile of medicare as a policy issue on both federal and provincial agendas, focusing on the need for clear language print and video materials for popular education.

♦ In a major paper, *Canada's Health Care System Under Free Trade*, Jackie Henwood, President of the Health Sciences Association of British Columbia, presented an analysis of threats to come if the North American Free Trade Agreement passes into law. Her paper draws the links between cutbacks to social programs, the privatization of insurance, services and facilities, the extension of patent protection on pharmaceuticals and the pressure to harmonize standards to the lowest common denominator. She recommends a tri-national campaign which ties the protection of medicare in Canada to reform of the health care systems of the U.S.A. and Mexico. (See also Ana Cristina Laurell and Maria Elena Ortega, "The Free Trade Agreement and the Mexican Health Sector," *International Journal of Health Services*, Vol XXII, No. 2, 1992, pp 31-37; and *Which Way for the Americas: Analysis of NAFTA Proposals and the Impact on Canada*, (November 1992) published by the Canadian Centre for Policy Alternatives in cooperation with Common Frontiers and the Action Canada Network).

The Canadian Union of Public Employees, the other major health care union, has spent some months reviewing the Campaign to Save Medicare and preparing a series of position papers to be released for debate by its members at a national health care conference in Montreal February 7-9, 1993.

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 158, Station D, Toronto M6P 3J8. Phone: (416) 588-9167 Fax: (416) 588-3765.

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, Lena Fung, 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.

Canadian Health Coalition Round-Table: The Road Less Travelled

Following a strategic review of its operations since the extra billing debates of the mid-1980's, the Canadian Health Coalition identified an urgent need for a comprehensive policy paper on Health and Health Care Reform to the year 2000. Part One, a policy round-table, *The Road Less Travelled*, brought together 14 health care analysts for 2 days of debate and analysis November 25th and 26th.

Participants in the Round-Table included:

- Patricia Armstrong, Professor of Sociology, York Institute of Health
- Morris Barer, health economist, Vancouver
- François Béland Professor of Sociology, University of Montréal
- Patty Bregman, lawyer, ARCH, Toronto
- Cynthia Carver, community health physician, Ottawa
- Ian Johnson, policy analyst, Nova Scotia Health Council, Halifax
- Karyn Kaufman, McMaster Faculty of Nursing, Ottawa
- Steve Kerstetter, National Council of Welfare, Ottawa
- Nancy Kotani, MSW, health promoter, Edmonton Board of Health
- Paul Lamarche, Faculty of Medicine, Laval University, Quebec
- Jonathon Lomas, health policy analyst, McMaster University, Hamilton
- Frances Scott, physician and Medical Officer of Health, Hamilton
- Arthur Schafer, University of Manitoba Centre for Professional and Applied Ethics, Winnipeg
- Evelyn Shapiro, University of Manitoba Faculty of Medicine, Winnipeg

Recommendations were made on a range of issues, including the Content of Care, Governance, Management, Financing and Delivery, Resource Allocation, and Human Resources.

In the short term, participants agreed on the need to concentrate public interest sufficient to put health care issues on government agendas. They emphasized the need for a shift to health determinants, and agreed as well on the need to combat the myths of the efficiency of user fees and privatization and the deficit as a result of social spending with short clear language educational materials. Especially in the post-Charlottetown context of federal-provincial relations, they emphasized the need for a coordinated strategy for both federal and provincial levels of government.

The result of their discussions will be summarized in a draft policy paper, produced for the Coalition by the Canadian Centre for Policy Alternatives in January 1993. The Coalition is attempting to secure funding to launch the paper and support a conference for popular sector activists in late April, 1993.

Ontario Health Coalition

A group of activists representing a broad coalition of consumers and providers has been working over the past 6 months or so to design a campaign for the popularization of health, health care and medicare issues around the province. Funding is currently being sought and secured with a view to coordinating actions for federal and provincial budgets early in the new year and a federal election toward mid-year.

For more information contact the Ontario Health Coalition, c/o 64 Augusta Avenue, Toronto M5T 2L1 [fax (416) 364-7832] or call Lee Zaslofsky at (416) 364-9602 x119 or Janet Maher at (416) 652-1459.▼ ***Janet Maher***

Drug Benefits Plan Undergoes Reform

On August 25, 1992 five initiatives pertaining to the Ontario Drug Benefits (ODB) Plan were implemented by the Ministry of Health. The Drug Quality and Therapeutics Committee (DQTC), at the request of the Ministry, provided the product specific recommendations required to begin a process of reforming the list of drug products covered under the ODB Plan. The modifications were designed to promote a more rational use of pharmacological resources, from a perspective of benefit, safety and cost.

Extemporaneous Mixtures

An extemporaneous product refers to any drug or combination of drugs prepared or compounded in a pharmacy to fill a prescription. In the past, with a few exceptions, the Ministry of Health would pay for the products created in this manner even though many lacked documented evidence of safety, efficacy or good value for the expense. Under the new scheme, greater restrictions will be applied for reimbursement by the Plan. The extemporaneous preparation must be: (1) a liquid formulation of a solid oral dosage form of a drug product already listed in the formulary; (2) for injection, prepared by or under the direct supervision of a person licensed as a pharmacist; or, (3) a dermatological drug product where the added active substances comes from a limited list of drugs.

In the past it was possible for a drug that did not meet the requirements for listing in the formulary to be covered by the ODB program if a physician requested that it be compounded by a pharmacist to make a unique product. This provided the opportunity for unproven therapies to be provided at the taxpayers' expense. Criteria #1 has been designed to close this loophole. Alternatively, in some situations it makes perfect sense to provide coverage for a non-formulary injectable product, e.g. to support the initiatives of the "hospital in the home" program. Therefore it is important that some parenteral antibiotics not listed in the formulary be made available to beneficiaries, and criteria #2 is designed to assist in this. Criteria #3 ensures that flexibility is maintained in the preparation of dermatologic drugs while eliminating support for unproven therapies. An example of a drug included in the list described in criteria #3 is hydrocortisone powder – which would allow the creation of different dosage concentrations of the glucocorticoid.

Over-the-counter (OTC) Products

More than 500 OTC products covered by the Plan were reviewed. A product was retained in the ODB Formulary if there was no alternative, and a lack of access to it could lead to life-, limb-, or organ-threatening disease; removal would likely lead to patients switching to more toxic or costly alternatives; or the product was used to treat a communicable disease with a significant public health impact. As a result of the review, 128 products were eliminated. The rationale for removal of some of these products is discussed below.

The DQTC recommended that sunscreens be removed as a benefit of the Plan, but at the same time presented the following points. Concern for exposure to UV radiation should not be solely addressed by the use of sunscreens. Behaviourial changes must also be promoted including the use of protective clothing and avoidance of sun-tanning. In addition, action on this issue should not be limited to the elderly and recipients of social assistance (the beneficiaries of the Plan). Education and access to sunscreens should be provided through schools and public health departments across the province.

The DQTC also recommended that payment for multi-vitamin preparations be discontinued, while retaining folate, B12, thiamine and vitamin D in the formulary. The use of multi-vitamin preparations as an effective nutritional supplement to compensate for poor dietary intake is not supported by any scientific literature. Thus a more efficient use of resources would be to spend government funds to provide food to the needy rather than paying for prescriptions of vitamin pills.

Dimenhydrinate (Gravol) was removed from the formulary. While research has validated its usefulness in treating motion sickness, the evidence also indicates that its efficacy does not carry over to vomiting from illness. For patients requiring an effective anti-emetic prochlorperazine or metoclopramide may be alternatives. Because of the potential for adverse effects associated with the latter, physicians should use them only in circumstances of bona fide need.

Antilipemic drugs

The DQTC did not recommend any major reforms in the use of antilipemic drugs after reviewing the evidence in the medical literature. Although considerable concern has been published about the inappropriateness of treating all patients with elevated lipid levels, clinical trials in the elderly are still required before a rational recommendation pertaining to this age group can be provided. The DQTC did recommend that clofibrate and d-thyroxine be removed from the formulary because there are safer and more effective (although more expensive) alternatives.

Reducing costs without changing benefit or risk

Two initiatives were designed to free up scarce resources while not limiting the current availability of safe and effective to encourage physicians to prescribe in larger quantities i.e. a minimum 100-day supply, drugs used in chronic therapy where a stable dose has already been achieved. This would reduce dispensing costs without adversely affecting therapeutic benefit. Drugs with a risk of overdose were excluded from this initiative.

Drugs suggested for larger quantity prescribing include diuretics, digoxin, phenytoin, glyburide, L-thyroxine and allopurinol. Although the program is intended for patients requiring the chronic administration of a stable drug dose, should a medication be discontinued or dose changed requiring the occasional disposal of medications – the program would still provide savings globally because the above are inexpensive in comparison to the dispensing fees.

Incidentally, the legislation covering the ODB Plan already permits dispensing of up to 250 days' supply of a drug product for seniors, and the pharmacist must dispense the full amount requested by the physician. Thus the new initiative is really an attempt to increase physician awareness of this cost saving option.

As a second method to obtain good value for each health care dollar spent, the Ministry removed some drugs that exceeded the 2% guideline for price increases. The DQTC reviewed 830 products that exceeded the guideline. 106 products were recommended for removal because there were safe and ef-

Continued on Page Four

MRG/CHC brief opposes Bill C-91

Pharmaceuticals bill will drive up costs

The following is a summary of a brief prepared by the Medical Reform Group and the Canadian Health Coalition opposing Bill C-91, the pharmaceuticals legislation introduced by the federal Progressive Conservative government.

The federal government has introduced Bill C-91 which will abolish compulsory licensing for drugs, with the consequence that the company introducing a new drug onto the Canadian market will be in a monopoly position until the patent on the drug expires – about 13 years. The government claims this bill will lead to increased investment in Canada by the multinational drug companies and at the same time consumers will be protected against undue price increases. Similar claims were made when Bill C-22 was passed in 1987. In this brief, the Canadian Health Coalition and the Medical Reform Group will first analyze the effects of Bill C-22 in order to see how well reality matches the initial set of predictions around the bill. We will then focus our attention on whether or not the new legislation is really necessary for the economic viability of the multinational sector of the pharmaceutical industry. Finally, we will conclude with an analysis of the likely impact on consumer prices should Bill C-91 be enacted.

To date the large generic drug companies have not suffered financially due to Bill C-22, but the full impact on them has yet to be felt. When Bill C-22 was introduced the government and the industry promised that it would lead to the creation of 2,000 new R & D jobs between 1988 and 1995 in the pharmaceutical industry. To date, R & D jobs have only been increasing at 215 per year, well short of the 250 necessary. Although prices on patented drugs have been rising at less than the Consumer Price Index since 1988, prices on all drugs, patented and unpatented, have been going up faster than the CPI. More importantly, the delay in the appearance of generic competitors means that significant cost savings are foregone. If there is a single generic competitor, the difference between the generic drug and the brand name one is 24%; when there are four generic competitors the difference is 65%. If there was generic competition for the cholesterol lowering drug Mevacor, the Ontario Drug Benefit Plan could be saving more than $1.4 million annually. Spending on R & D in Canada has increased significantly, but most of the money is being used to fund clinical trials, not to do basic research. In a survey of leading medical researchers, 90% foresaw a likely conflict of interest in accepting money from the drug industry; 80% deemed pharmaceutical clinical research "me too" research; and 40% were worried about a potential delay in the publication of unfavourable results.

The pharmaceutical industry in Canada has consistently shown high profit levels. Over the decade ending in 1987 the pretax rate of return on equity for drug manufacturers averaged 34.5% compared to an average for all manufacturing industries of 15.2%. Despite these enviable figures the industry argues that it needs increased patent protection in order to realize an essential return on its investment in the drug discovery and development process in Canada. The drug companies claim that it takes a global investment of US$231 million to bring a new drug from discovery to marketplace and only one in three drugs recover their R & D costs. However, the studies that the industry uses to back up these claims deal with only a very narrow universe of new drugs and drug companies and it is not clear that their results can be generalized in the way that PMAC does. Moreover, recent research has challenged their conclusions. A survey of 39 American, Japanese and European companies found that the large majority said it took less than US$200 to research and develop a new drug.

New drugs are launched in Canada at a substantial premium compared to older, and in many cases, just as effective drugs. Between 1982 and 1989 antihypertensives, antiarthritics and ulcer medications introduced onto the Ontario market were priced 35-60% higher, on a daily treatment cost basis, than existing drugs. With compulsory licensing newly introduced patented medications are subject to price competition from generic products within seven to ten years. Without compulsory licensing there is no price competition until the patent expires. At this point that is an estimated 13 years, but if approval times for new drugs drop, as both the government and the industry hope they will, then instead of 13 years it could be 14 or 15 years.

The Medical Reform Group and the Canadian Health Coalition believe that the benefits from Bill C-22 have not been clearcut and that the costs may only be beginning to be recognized. Therefore, we cannot accept the government's pronouncements about the effects of Bill C-91. Furthermore, we can find no evidence that the new bill is necessary for the economic health of the industry. On the contrary, there is good reason to believe that the elimination of compulsory licensing will only serve to drive up the cost of prescription drugs. Therefore, we recommend that the government abandon its plans to proceed with Bill C-91.▼

Ontario Drug Benefits Plan
Continued from Page Three

fective alternatives still in the formulary, while 724 products were retained because it was felt that despite the increase in price, it was in the public interest to continue to make these products available under the Plan. It is important for physicians to note that the published list of products removed refers to the brand name of the product only, and that in almost all cases a generic equivalent is still available, e.g. Haldol has been removed as an ODB benefit but haloperidol manufactured by other companies is still covered by the Plan.

Conclusion

For a number of years, the DQTC has been trying to restructure the ODB Formulary, to promote rational prescribing that is evidence based. Until recently there has been only modest success in this area. Due to the unfortunate economic climate and increasing costs of the ODB program, the government has provided the committee with an opportunity to institute reform. Although many of the changes will help the government save financial resources, the recommendations by the committee have been founded primarily in the promotion of optimal drug utilization.▼

Mitch Levine

Patent Greed

The multinational drug companies strike again

The Conservative federal government has once again caved into the multinational drug corporations. Less than five years after the Mulroney Tories extended the market monopoly of brand name drug firms to 10 years, they are now moving to double this period of legislated price-fixing to 20 years.

Here are the facts:

If approved as introduced, Bill C-91 will all but eliminate the environment of drug price competition that as saved the Canadian health care system billions of dollars over the last decade. The cost of prescription drugs will increase dramatically, needlessly robbing our medicare system of already-scarce resources.

To prevent debate, Bill C-91 was unveiled on June 23, 1992, the same day the House of Commons adjourned for its summer recess. And in an additional twist that added insult to injury, International Trade Minister Michael Wilson made the bill retroactive to December 21, 1991, the day Director-General Arthur Dunkel released a revised draft of the General Agreement on Tariffs and Trade (GATT).

The link with GATT produced a predictable and justified outcry from generic drug manufacturers. The Dunkel proposal is tentative and could be rejected by GATT's 108 member nations. Among the first to expose the government's all-too-blatant surrender to the multinational was the *Toronto Star*. In an editorial the newspaper bluntly accused the Tories for using "trade talks as a ruse to give the multinational drug firms the protection in Canada they've been lobbying for all along."

Bill C-91 will lead to much higher prices for new prescription drugs because it will allow brand name manufacturers to charge monopoly prices for up to 10 additional years. In practical terms, this will virtually eliminate meaningful price competition related to lower-priced substitute drugs. Why? Because in 20 years most drugs become obsolete and are replaced by newer alternatives, which also enjoy patent protection.

It is unusual for a government to propose such far-reaching legislation retroactively. Although generic manufacturers have invested millions in research and application techniques, generic licences granted after December 21, 1991, would be deemed invalid by Bill C-91. This would apply even in cases where generic manufacturers filed applications for licenses prior to this date. The result, if the bill becomes law, is that a whole group of drugs scheduled to become "generic" would retain lucrative monopoly protection for many additional years.

Pampering the multinationals

This is not the first time the federal Tories have caved in to American multinational drug company pressure. Prior to 1987, Canada had far more sensible patent laws. The system, called "compulsory licensing", allowed generic companies to apply for a license to import, make, use or sell cheaper versions of brand-name drugs soon after the originals appeared on the market. In return, they paid a four percent royalty to the patent-holding firm.

This controlled generic competition kept drug prices down, and saved the health care system billions of dollars. A federal inquiry headed by Harry Eastman of the University of Toronto in the mid-1980's concluded that Canadians were saving more than $200 million a year by using generic drugs.

Although the multinationals have strongly opposed compulsory licensing, they have yet to prove that they have been harmed by it. The Eastman report showed that generic competitors comprised only 3.1% of the Canadian drug market in 1983, and that the pharmaceutical industry had profit levels at least twice the average of all other manufacturing industries. Since then, as the accompanying table shows, the pharmaceutical industry in Canada (which is at least 90% controlled by foreign-owned corporations) has piled up profits that far exceed the average for all industries.

The multinational offensive

Ever since compulsory licensing was introduced in Canada in 1969, multinational pharmaceutical companies have strenuously lobbied the government to change the law on grounds that it was the "thin edge of the wedge." If Canada could implement laws permitting competition from generic drug manufacturers, the practice might spread to other countries.

Rate of Return on Equity Before Taxes, 1972-1987

Year	Drug Industry (%)	All Industries (%)	Rank Among 87 Industries
1972	24.7	14.1	8
1973	24.3	19.7	17
1974	27.4	22.8	19
1975	25.0	17.8	12
1976	22.7	15.8	15
1977	21.4	14.7	16
1978	22.7	17.4	20
1979	28.3	21.9	17
1980	30.1	20.1	10
1981	31.0	17.4	6
1982	30.0	5.4	7
1983	33.9	9.9	3
1984	40.3	15.7	2
1985	41.1	12.7	3
1986	45.5	14.9	3
1987	42.4	16.2	1

Statistics Canada. *Corporation financial statistics-detailed income and retained earning statistics for 182 industries*. Ottawa, various years.

Source: Joel Lexchin "Pharmaceutical, Patents and Politics: Canada and Bill C-22", CCPA, 1991

When the big-business-backed Mulroney government was elected in 1984, the multinationals seized their chance to reverse the legislation. They intensified their lobby campaign by using the ultimate weapon at their disposal: the proposed Canada-U.S. Free Trade Agreement. First, the American drug giants used their political clout to push their way into the free trade negotiations. Edmund Pratt Jr., president of Pfizer, a leading American drug company, chaired the U.S. Trade Representatives' Advisory Committee for Trade Negotiations and the Emergency Committee for American Exports, representing about 60 multinationals advocating freer trade.

The result was Bill C-22, tabled by the Tories in 1986 – legislation guaranteeing brand name firms up to 10 years of market exclusivity for all new drugs. Despite opposition from the governments of Ontario, Newfoundland, Prince Edward Island and Manitoba, and public opinion polls showing 90% of Canadians opposed to Bill C-22, the government, driven by corporate ideology and its free trade agenda, forged ahead.

Continued on Page Six

Patent Greed
Continued from Page Five

Months before the bill appeared, reports linking the proposed law to free trade were featured in newspapers across Canada. Prime Minister Mulroney denied any association between the bill and free trade. But a signed copy of the draft text of the bilateral agreement was eventually leaked to the media. It contained the following passage: "Canada has agreed to pass the pending amendments contained in Bill C-22 in respect of compulsory licensing of pharmaceuticals.

Bill C-22 became law in 1987, but it turned out to be only a first step towards much greater patent protection for the multinationals. This was confirmed several years ago when a set of briefing notes belonging to former U.S. Treasury Secretary James Baker was published in a U.S. trade journal. The notes spoke of the Canadian government's commitment to pass Bill C-22 and referred to a Canadian pledge to review more extensive patent protection within 10 years "for no U.S. concessions."

It is widely accepted that Canadian free trade negotiators were desperate for a deal. But without any American trade-offs? It seems safe to conclude now that the current legislation, Bill C-91, was in the works years before the advent of GATT negotiations that are now being cited as a justification for the legislation.

A global crusade

Canada is not the only country affected by American foreign policy on drug patents. In recent years, several countries have been threatened with U.S. trade sanctions unless they agreed to pass strong patent legislation. Former U.S. President Ronald Reagan imposed economic sanctions totalling $200 million on Brazil. These included retaliatory tariffs and a ban on certain goods after Brazil refused to grant patent rights to American drug manufacturers. The U.S. government has also threatened Argentina, Chile and South Korea with similar sanctions.

What this amounts to is a global corporate crusade to punish countries that try to resist the bullying tactics of the American-dominated pharmaceutical industry. Although considered to be among the most profitable of all manufacturing industries, the drug multinationals clearly want to eliminate generic competitors. Their bid to protect "intellectual property rights" is a thinly-veiled campaign to tighten their monopolistic control of the drug industry and to stop generic companies from cutting into their profits. As one of the largest contributors to U.S. political campaigns, the American Pharmaceutical Manufacturers Association is well-placed to influence U.S. foreign policy.

What about R & D?

Although the multinationals promised to vastly increase Research and Development (R & D) in Canada, only 26.7% of R & D spending in 1990 was on basic research, the area where drug discoveries are made. This is far lower than the comparative U.S. figure of 46.5%

In reality, most R & D spending in Canada involves applied research, which consists of testing potential drugs (usually discovered in other countries) on animals and humans in order to pass Canadian food and drug regulations. Some money is also spent on "product development" research, which includes the testing of different forms of certain drugs — such as pills, tablets, creams and solutions — to determine products consumers prefer most.

It is unlikely that the promises of the multinational drug companies to make Canada a meaningful centre for research and development will ever come to pass. The Eastman Commission did not hold out hope that Canada would be a world-class leader, either in pharmaceutical research or production. These corporations prefer to conduct R & D at head offices in the U.S. or Europe, where their corporate decision-makers and most of their facilities are located. This minimizes cost and duplication.

Unfortunately, Canadian drug manufacturers that have begun to invest millions in R & D have had the rug pulled out from under them. By passing laws to protect and increase the profits of foreign-owned multinationals, the federal government has impeded the growth of the domestic generic drug industry, which creates jobs and reinvests its profits in Canada.

Drug prices skyrocket

The Canadian Drug Manufacturers Association, representing mainly generic drug companies, says that extended patents have led to exorbitant introductory drug prices. For example, the AIDS drug treatment, AZT, costs about $1,000 per month per patient. Since generics cannot now be sold for 10 years (rising to 20 years under Bill C-91), new drugs prices are guaranteed to remain artificially high.

The Patented Medicine Prices Review Board was created by Bill C-22, supposedly to monitor drug prices. However, its small staff and limited access to pertinent R & D information from parent drug companies makes its assessments of drug prices suspect.

There is little doubt that prescription drug prices have escalated in the last five years. Green Shield, one of the country's leading insurance companies, recently released *A Report on Drug Costs*. This study was conducted for employers and unions upset at rising premium costs for extended health care plans that include drugs.

Green Shield's conclusions confirmed the worst suspicions linking extended patent protection to higher drug prices. Between 1987 and 1991, the average cost of a Green Shield prescription claim soared by 11.4% (compounded annually), two and a half times the rate of inflation. Statistics show that the average drug cost (per insurance claim) rose 53.8% over a four-year period, while the Consumer Price Index (CPI) rose by only 20.9%.

When the Mulroney Tories passed Bill C-22 in 1987, consumers, unions, health groups and generic drug producers warned that the price of new drugs would soar because there would be no competition from generic manufacturers for up to 10 years. According to the Green Shield study, new drug prices have had a major impact on average drug costs, since most new drugs are more costly than existing drugs. For example, the average cost per claim for new drugs in 1991 was $34.12, more than twice the $16.04 average claim cost for existing drugs. On average, generic drugs cost 30% to 40% less than brand name equivalents.

Bill C-91 threatens medicare

Bill C-91 is a new and potentially deadly Tory nail in the coffin of medicare. Just as the Mulroney government is chopping billions of dollars from health and education payments to the provinces, it is dramatically increasing the already-excessive profits of the multinational drug companies. Higher drug prices mean increased health care costs when provincial drug plans and group insurance programs are already struggling to cope with rising financial pressures. Whether through increased taxes

or higher insurance premiums, Canadian consumers stand to lose billions.

If prices continue to soar, the future of provincial drug plans is bleak. Already, the level of deductibility in the B.C. provincial drug plan has been raised by $50 (to $375), and in Saskatchewan, reimbursements for prescription drugs have been reduced. Now the Ontario government is considering proposals; to implement user fees for its provincial drug plan, which covers seniors and social assistance recipients.

CUPE members also stand to suffer because employers, faced with higher costs, will inevitably call for concessions at the bargaining table. This could take the form of higher levels of deductibility or various co-insurance features to reduce premiums. Hospitals and nursing homes can also be expected to look for cutbacks – most likely in wages and benefits – to offset higher spending caused by rising prescription drug prices.

The American multinationals are formidable opponents. But they should not be allowed to dictate Canadian health care policy or grab such an exorbitant share of our shrinking Canadian health care resources. CUPE members should make their opposition to Bill C-91 known to the Mulroney government and to every federal Member of Parliament as often and ad forcefully as possible. In summary, Bill C-91 is a bitter pill that Canadians should refuse to swallow.▼

Ruth Scher

Reprinted from The Facts, Dec. 1992 issue, published by the Canadian Union of Public Employees.

Canadian health-care system superior to U.S. model, group told

By Adrian Humphreys

This article appeared in The Hamilton Spectator November 2, 1992

George Bush should have been listening.

Bill Clinton and Ross Perot should have been there.

A checklist of reasons why the Canadian health-care system is superior to the American model was presented yesterday at a conference at McMaster University's faculty of health sciences.

Nodded yes

And many in the group, largely composed of American doctors and health-care professionals, were seen nodding in agreement.

Dr. Gordon Guyatt, clinical epidemiologist and biostatistician at McMaster, spoke to the annual meeting of the Health of the Public group, comparing the vastly different approaches to health care in Canada and the United States.

His findings fly in the fact of what United States President George Bush has been saying on the campaign trail, and would serve Mr. Clinton or Mr. Perot well if either wins tomorrow's presidential election, he said.

"There is a very different picture than the one presented by the American President," Dr. Guyatt told the group of about 50 health professionals.

"Canadians seem to be more satisfied with their health care," Dr. Guyatt said of surveys and studies comparing the systems.

But more importantly, he added, no matter how you study it, Canada's health-care system is better. We live longer – with an average life span of 77.1 years against the American 75.3 – and have a lower infant mortality rate – 7.9 baby deaths per thousand, compared to 10.4 in the United States.

Dr. Guyatt said studying Canadian and American systems is fascinating because the countries share similar cultures and histories, but picked radically different health-care systems.

"With Canada, we have the most socialized health-care system in the world," he said. Canada's is a government-run system where patients face no deductible, no up-front payment and no pay-per-use medical costs.

The U.S. system is a private, market-driven system.

Dr. Guyatt spoke of studies that looked at the two systems from five perspectives – consumer satisfaction, physician satisfaction, access to services, health of society and control of expenditures.

He said some of the findings on public satisfaction and success of the health-care system might be expected, but there was at least one surprising result.

The United States' privately run system costs 13% of its Gross National Product, while Canada's costs only 9%.

Administration

Most of the extra U.S. money is sucked away in administrative costs associated with private medical-insurance schemes, Dr. Guyatt said. Administration accounts for about 24% of American health-care costs by only about 11% in Canada, he said.

"There are some waiting lists in Canada," he said, addressing the major criticism of Canada's system by American politicians.

"But there are no waiting lists for emergency surgery, some in urgent surgery but most are for elective surgery," he said.

Of the 17 health science schools involved in the Health of the Public network, McMaster is the only Canadian one.▼

Minutes of Medical Reform Group Fall Meeting

MRG debates how MDs should be paid

The following are the edited minutes of the Medical Reform Group's fall general meeting of 18 November 1992, held at the Davenport-Perth Community Health Centre, Toronto: About 25 members were in attendance.

The topic of the fall general meeting was "Is There a Future for Fee-For-Service?" As background, the November 1992 issue of *Medical Reform* contained articles by the Resource Allocation and Primary Care Working Groups, as well as a summary of a discussion paper on alternative payment mechanisms produced by the College of Family Physicians. of Canada.

Current MRG policy on payment mechanisms dates from May 1980 (*Resolution MRG5*). The relevant section of that resolution states:

I. WHEREAS there is considerable evidence from other countries of the

Continued on Page Eight

Minutes of Fall Meeting
Continued from Page Seven

advantages of systems of physician payment other than fee-for-service such as salary and capitation,
AND WHEREAS there is a significant number of physicians in Ontario who are interested in working under such alternative systems of payment,
AND WHEREAS Government of Ontario support to date for such alternatives, as in the Health Service Organization Programme, while laudable, is still inadequate,

BE IT RESOLVED THAT
1. the MRG call upon the provincial government to increase its support for experimental programmes in which significant numbers of physicians would be engaged to practise on salary and capitation as well as fee-for-service,
2. at the end of an appropriate period of time the relative benefits, in terms of cost, quality of care, and patient/physician acceptance, be assessed in a public forum, with a view to the establishment of future health funding priorities.

At the same meeting in May 1980, a related resolution on community health centres was passed (*Resolution MRG6*). It states:

I. BE IT RESOLVED THAT the MRG support the establishment of community health centres as a major method of primary health care delivery, and call for full provision of funds by the provincial government to this end. By a community health centre, the MRG refers to a team of health care workers operating out of a single physical facility, dedicated to the practice of health promotion, health education, and the diagnosis and management of illness. The power to decide on the disposition of funds and the programmes and practices of the centre would be shared by centre users and staff.

II. BE IT RESOLVED THAT the MRG consider that an appropriate method of financing community health centres should
1. take into account the demographic characteristics of each centre's population,
2. eliminate the incentive to high volume practice,
3. provide funds for educational and home services,
4. be negotiated between the government and the centre.
(Passed May 24, 1980)

It was with this background that the November 18, 1992 general meeting was called to order by Rosana Pellizzari.

Haresh Kirpalani (who is on salary) summarized the discussions of the Resource Allocation Committee regarding payment mechanisms for physicians. A summary of these discussions appeared in the November 1992 issue of *Medical Reform*. Haresh said that in light of changing events, it is time for the MRG to review its position on payment mechanisms. Other bodies, including the Ontario Medical Association, are also debating the issue.

The fee-for-service system encourages unnecessary utilization, though it is recognized that over-utilization is not solely physician-driven. There is a sense among many physicians that they are above and beyond being paid by salary. Capitation as an alternative avoids putting physicians on salary.

Bob James (whose practice is on capitation) summarized the position of the Primary Care Working Group, which also appeared in the November issue of *Medical Reform*. Bob said that there are still some advantages to fee-for-service. Fee-for-service is malleable to providing incentives to change patterns of practice. He would be loath to eliminate fee-for-service entirely. Capitation allows physicians a sense of ownership which they do not have on salary. It is true that under capitation, some physicians pad their rosters. There is a danger under salary that you will do only what you are paid to do: a danger of a bureaucratic mentality developing.

Mimi Divinsky (who is on fee-for-service) presented **Philip Berger's** comments to the meeting, since Philip (fee-for-service) was not able to attend. One of his arguments is that the fee-for-service system is so entrenched that it would take a long time to get rid of it. Therefore it might be a better approach to try to change fee-for-service in creative ways to create incentives to encourage what should be encouraged and discourage what should be discouraged. One idea would be to limit the number of billings per day.

In the discussion that followed, **Bob James** said that one flaw in the present capitation system is that it doesn't pay you more if you are doing obstetrical care than if you are not.

Vera Tarman raised the example of HIV+ patients who need to be seen every two weeks. It would be hard to take care of such patients under a capitation system. Capitation encourages the rostering of healthy patients, so a special population of patients which is very sick could not fit well into a capitation system.

Gord Guyatt said that capitation can be flexible in having extra incentives, for example for achieving a certain level of vaccination. He noted that we are addressing payment mechanisms for primary care, not specialists.

Mimi Divinsky said that university professors are paid a salary. Why should we assume that professors can be trusted to work on their own initiative while salaried, while physicians could not be trusted to work unless they are paid each time they do a procedure?

Catherine Oliver said that she thinks that capitation is **the** way to go in general. A broadly-based capitation system would place some financial limits on physicians because there are only so many patients to roster. In a salaried setting at a community health centre, she does not know who her patient population is. If you know who your population is, you can call them in for flu shots, etc.

Michael Rachlis said that in Saskatoon, costs for patient populations served by CHCs were 20 per cent lower than for those served under fee-for-service; in Sault Ste Marie, 30 per cent lower. The savings were mainly in reduced hospital utilization and lower drug costs.

Bob James said that it would be useful to compare cost/patient/year in capitation HSOs versus CHC.

Gord Guyatt said that there is a significant difference between having a capitation-based *system*, and having a few islands of capitation in a fee-for-service sea. One valuable step to take would be to take responsibility for the tariff schedule out of the hands of the OMA committee which sets it.

Michael Rachlis said that the provincial ministers of health are meeting much more frequently and coming up with common policy. One of their goals is now to move physicians off the fee-for-service system; one stated goal is getting one third off fee-for-service within five years.

There is no real accountability under any of the three methods of payment. All three systems produce examples of gorging at the public trough. We need financial accountability and audits or there will be abuse under any system.

On Bob James' point of capitation giving doctors a sense of ownership: if we believe, as the MRG's third principle states, that others, e.g. nurses, midwives, etc., have an important role to play in the health care system, then you don't want doctors to have ownership, since this conflicts directly with the goal of democratic control and recognition of the equally important role of other health care providers.

Haresh Kirpalani said that physicians can be bought off. They will be amenable to other payment mechanisms if those mechanisms put money in their pockets.

Don Woodside said that in the future there will be unemployed MDs. He quoted Philip Berger as saying that it takes massive amounts of paperwork and a lengthy process of application to get a small one-time grant for a social service organization. Yet anyone with an MD degree can set up an office and start billing OHIP hundreds of thousands a year with no questions asked.

Bob James spoke briefly about a proposal he has sent to the Ministry of Health which would see several practices affiliating so that their combined patient populations can support services which an individual practice cannot justify. For example, his practice of 1400 isn't large enough to support a physiotherapist or midwife, A combined practice of 14,000 could support them.

Michael Rachlis said that two years into the Ontario NDP government, there is still no strategy for primary care. The community health framework which was supposed to be developed is going nowhere. The government funds six new CHCs a year, and no one is assessing what they do in any meaningful way. Some HSO physicians are taking home huge sums, more than highly paid surgeons. Unlike other physicians, they are not subject to any ceiling, any clawback. Nothing much good is happening in development of good models for either CHCs or HSOs. The best fee-for-service family physicians have been losing income because they haven't increased volume and fees haven't gone up while costs, including the GST, have. Meanwhile it looks as if the rednecks are taking over the OMA again.

Bob James said that at the time they closed the HSO program for review, there were sixty applications from practices wanting to become HSOs.

Don Woodside said a payment mechanism needs to be hitched to a model of service provision to really generate excitement. Can we organize a conference to talk about models of service provision?

Gord Guyatt said that we are interested in a structure of payment and primary care provision which recognizes the social and economic roots of ill health, which encourages strategies to address these causes, which is based on rational planning, which lends itself to assessment of results, which gives a greater role than at present to non-physicians. Fee-for-service is not very compatible with rational planning and the involvement of non-physicians in decision-making and the provision of care. Capitation and salary are much more compatible with these goals. Therefore we support the system moving toward capitation and/or salary.

Bob James said the system should be biased strongly to capitation while recognizing that salary and fee-for-service can have a role to play.

Gord Guyatt said we should state that community health centres have a role to play.

Rosana Pellizzari said capitation should allow for enhanced funding for health promotion where appropriate. Such enhanced funding would have to be applied for and justified separately from core funding.

Gord Guyatt said he couldn't imagine how fee-for-service would be more compatible in achieving our stated goals than capitation would be.

Bob James suggested obstetrics might be more suited to fee-for-service.

Rosana Pellizzari said that under capitation, you can do obstetrics yourself or you can hire someone to do it.

Don Woodside said fee-for-service might be best for HIV care and women's clinics.

Rosana Pellizzari asked why this would be so if you had rational planning at the level of a community of 60,000.

Don Woodside said there are probably some eventualities where fee-for-service would be useful.

Gord Guyatt said we should favour capitation but we are not saying there is no role at all for salary or fee-for-service.

Rosana Pellizzari said that this shifts the ownership away from the physician toward rational planning.

Michael Rachlis endorsed the idea of having a conference to get discussion going. We could aim either at family doctors, or at other groups like nurses. Most groups are starting to pick up that nothing much is happening within the Ontario Ministry of Health. There is not enough discussion of primary care policy going on.

Rosana Pellizzari asked: 1) What consensus do we have on policy? 2) What do people think of the idea of a conference?

Steve Hirshfeld said that the discussion has shifted from an even-handed approach favouring both capitation and salary, to one favouring capitation. He would like us to support both salary and capitation.

It was agreed that Steve's position is the one we should adopt.

Rosana Pellizzari noted there are three types of HSOs: physician-sponsored, university-sponsored, and community-sponsored.

Gord Guyatt said our policy should favour more accountability, monitoring of efficiency, and high-quality care.

Haresh Kirpalani said we should print the position we have arrived at here and circulate it to the membership via the newsletter to solicit the reactions of members who aren't here tonight.

The following position was endorsed: That the MRG supports structures of payment and primary care provision which recognize and address the social and economic roots of ill health, which are based on rational planning, accountability, and monitoring and assessment of results, which give a greater role to non-physicians, and which favour capitation and salary as payment mechanisms.

It was agreed to pursue the idea of a conference. The Steering Committee was asked to initiate planning for such a conference.

Bob James urged the Steering Committee to ask the Ministry to get going on negotiation of a model for HSOs. **Michael Rachlis** suggested writing a letter to the Minister or Deputy Minister noting government inaction on primary care with dismay. The Steering Committee asked Bob to come up with the first draft of such a letter.

The meeting adjourned at approximately 10 p.m.▼

Minutes by Ulli Diemer

Attack on Canadian health care system called very misleading

The following letter appeared in the August 6, 1992 issue of the New England Journal of Medicine, provoking a response from members of the Medical Reform Group Steering Committee.

THE AMERICAN HEALTH CARE SYSTEM

To the Editor: Having recently moved to the United States from Canada, I was very interested in the article by Iglehart (April 2 issue)* on the American health care system. In Canada, where the chief financial constraint is the available global budget provided to each health care institution, the physician generates expense rather than revenue for the institution and is forced to choose patients for available therapy on the basis of the likelihood of a favorable outcome. Thus, the physician subtly becomes a salesperson for the system rather than an advocate for the patient. To Americans this may be unacceptable, but Canadians accept it for the most part.

In Quebec, where I practiced, the effort on the part of the provincial government to limit the proliferation of technologically advanced medicine has led to the unavailability of certain services for certain patients. For example, marrow transplantation centres usually do not refuse outright to take patients, but instead put them on a waiting list. This list is updated periodically, and basically, the patients with the greatest chance of long-term survival move up the list. The physician is put in the unenviable position of rationing the resources.

In this politically dominated system, sarcastic remarks by physicians and administrators alike – such as "Dead people don't vote" and "The Canadian health care system is the best in the world until you get sick" – often ring true to those who spend their working lives in it. The most disquieting aspect of the Canadian system is that it is still perceived as being too expensive. This portends an even greater disparity between the Canadian and U.S. systems in the future.

John Lister, M.D., F.R.C.P.C.
University of Pittsburgh Medical Centre

*Iglehart, J.K. The American health care system – introduction N Engl J Med 1992:326:962-7.

HEALTH CARE IN CANADA

The following response to Dr. Lister's letter was written on behalf of the Medical Reform Group Steering Committee and appeared in the November 26, 1992 issue of the NEJM:

To the Editor: The letter from Dr. John Lister about the Canadian health care system (Aug. 6 issue)[1] describes efforts by Canadian governments to contain health care costs. The letter is very misleading, however, in its presentation of the effect of these efforts on physicians and on health care.[2,3]

Dr. Lister believes that hospitals' global budgets lead the physician to become "a salesperson for the system rather than an advocate for the patient." In fact, physicians are being asked to avoid unnecessary investigations and hospitalizations and thus to minimize barriers to access for the patients who could most benefit from these services. There are no incentives to act on behalf of the system and not the patient, a situation that contrasts with some structural and reimbursement schemes within American health care.

Dr. Lister cites disparaging remarks made by Canadian physicians about their health care system. Despite the very real tensions created by attempts at cost control, both physicians[4] and residents[5] in Canada are extraordinarily satisfied with the system. For example, 88 percent of Ontario physicians are either moderately satisfied or very satisfied with their ability to meet the needs and demands of patients, whereas only 18 percent of Canadian residents think there is a serious problem of access in their country, as compared with 75 percent of US residents. These data explain why representatives of organized medicine in Canada are correcting negative, distorted impressions of Canadian health care that are being propagated in the United States.[6]

Dr. Lister ends his letter by referring to the likelihood of an increasing disparity between the Canadian and US systems. The present disparities include the universal, equal access of Canadians to high-quality health care, as compared with the limited access to even basic primary care among millions of uninsured and underinsured Americans; the far greater degree of satisfaction with the health care system among Canadians than among Americans; the better health status of Canadians, as judged by such indicators as life expectancy and infant mortality; the reduced costs and massively reduced administrative waste in the Canadian system. In view of trends toward increasing numbers of underinsured and uninsured Americans and toward increasing administrative costs in the United States as compared with decreasing administrative costs in Canada, it appears that in the absence of major structural changes within the US system, Dr. Lister's prediction of increasing disparities may well be accurate.

Gordon Guyatt, M.D., F.R.C.P.(C)
Haresh Kirpalani, M.D., F.R.C.P.(C)
McMaster University Health Sciences Centre, Hamilton, Ontario L8N 3Z5
For the Medical Reform Group of Ontario

1. Lister, J, The American health care system — introduction. N Engl J Med 1992;327:438
2. Relman, AS. Dealing with conflicts of interest, N Engl J Med 1985;313:749-51.
3. Schiff RL, Anself DA, Schlosser JE, Idris AH, Morrison A, Whitman S. Transfers to a public hospital: a prospective study of 467 patients. N Engl J Med 1986;314:552-7.
4. Kravitz RL, Linn LS, Shapiro MF. Physician satisfaction under the Ontario Health Insurance Plan. Med Care 1990;28:502-12.
5. Hayward RA, Kravitz RL, Shapiro MF, The US and Canadian health care systems: views of resident physicians. Ann Intern Med 1991;115:308-14.
6. Sullivan P. Health care system serves Canada well, Alberta president tells American MDs. Can Med Assoc J 1990;142:237-8.▼