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 13, Number 2 — May 1993

Ways to save money without compromising quality of care

The following suggestions were prepared by the Medical Reform Group's Resource Allocation Committee.

Independent health facilities

The Independent Health Facilities have been a step forward and provide an opportunity for major cost saving. The recent decision to limit funding for obstetrical ultrasound is an example of an excellent decision which is likely to improve the cost-effectiveness of obstetrical care. Similar decisions could be made for tests such as dual photon absorptiometry, exercise stress tests, echocardiograms, and ear oximetry. There should be a democratic decision-making body which decides on the targets of constraint. The deliberations of this body should be open to public scrutiny. The mandate of this body should include obtaining expert consultation concerning the evidence regarding effectiveness of the target procedures, and what utilization would be appropriate.

Guidelines for physician practice

Positive steps in the development of guidelines for clinical practice have included the Scott Task Force recommendations regarding screening for blood lipid abnormalities and recommendations regarding Caesarean section. These activities should be extended. Currently available evidence-based guidelines regarding screening activity should receive the imprimatur of the government and representatives of the medical profession. Guidelines regarding use of common laboratory tests should be developed. Given the attitudes and decision-making structures within the medical profession, the implementation of these guidelines will provide (even after receiving official sanction) a tremendous challenge. Once guidelines have been developed, a thoughtfully constituted committee should be charged with their implementation. This committee should include members of the medical profession, representatives of the government, and democratically chosen public representatives. Their deliberations should be open to public scrutiny. Strategies they may choose to aid implementation of guidelines would include alterations in the fee structure, focusing on "educational influentials" (physician-leaders whose behaviour has a major influence on the behaviour of their colleagues), "counter-detailing" (visits to individual physicians with one-

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INSIDE

Ontario's NDP government: Part of the problem or part of the solution?

The Medical Reform Group's spring general meeting will be devoted to a discussion of the actions of the Ontario NDP government. The government's direction is the subject of a great deal of debate, in the health care sector and in the province at large, and MRGers have been expressing a desire for a full debate on the government's agenda and how the MRG and other organizations should be responding to it.

The general meeting will be on Thursday June 10 at the Davenport-Perth Community Health Centre, 1900 Davenport Road Toronto.

The meeting itself will begin at 7:30 p.m. Dinner will be catered in, and will be from 6:30 to 7:30. If you want to eat dinner, please call (416) 588-9167 by Friday June 4 so we'll know how many dinners to order.

The registration fee for the meeting, including dinner, will be $10.

There will be another issue of *Medical Reform* which will be mailed on June 1. We are hoping to publish several opinion pieces on the NDP in that issue. Members and readers are invited to send articles, letters, faxes, etc., setting out their thoughts and opinions on what the government is doing and what the response should be. These do not have to be long: short items two or three paragraphs in length are as welcome as longer pieces. All submissions must in be by Thursday May 27. Mail your submissions to *Medical Reform*, P.O. Box 158, Station D, Toronto M6P 3J8, or fax (416) 588-3765.

To kick off the debate, Haresh Kirpalani, a member of the MRG Steering Committee, has written an opinion piece which appears in this issue. Your responses are invited.▼

MRG - Lapdog to the NDP?

By Haresh Kirpalani.

I do not wish to be an iconoclast. Occasionally however the direction I see us in the Medical Reform Group moving in makes me very itchily iconoclastic and noisy, and I find myself needing to let off some steam. This is one of those times.

This polemic on the MRG's policy direction over the last few years nevertheless needs to start off with my respects. These respects are to the members of the MRG who have had the courage of their convictions to slug it out with Reaction (I have an old fashioned view that imbues a William Blake-ean Devilish persona to Reaction), while openly identifying themselves as members of the Medical Reform Group.

I have learnt an awful lot about integrity from these individuals. We all know who these individuals are, because they are cited when they speak and write — as being members of the MRG. They are not cited as simply "physicians", as some members of the MRG seem to prefer when they are speaking publicly.

That gripe aside, my aim is to explore why the MRG has lost its edge in the current climate, as I believe it has. This exploration is predicated on the assumption that a full and frank discussion internally will help the organisation to arm itself for the challenges of the external world. Externally I fully support the MRG, but internally I will carp about it!

On most issues, I should add that in my view, the MRG has been correct, particularly on the founding principles. And then, after a struggle, on the principles of resource allocation. Even on the Gulf War, though that upset some. The MRG also remains almost the only game in town. But this "almost" is a very resonant word, for "Fings ain't what they used to be." Other groups are emerging, and perhaps a different type of coalition is now needed.

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Medical Reform

Medical Reform is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at $25/year. Arrangements to purchase multiple copies of individual newsletters or of annual subscriptions at reduced rates can be made.

Articles and letters on health-related issues are welcomed. Submissions should be typed (preferably double-spaced), or submitted on IBM-compatible computer disks (any program, but tell us which program you used.)

Correspondence should be sent to Medical Reform, P.O. Box 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.

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The Medical Reform Group of Ontario is an organization of physicians, medical students, and others concerned with the health care system. The Medical Reform Group was founded in 1979 on the basis of the following principles:

1. Health Care is a Right
The Universal access of every person to high quality, appropriate health care must be guaranteed. The health care system must be administered in a manner which precludes any monetary or other deterrent to equal care.

2. Health is Political and Social in Nature
Health care workers, including physicians, should seek out and recognize the social, economic, occupational, and environmental causes of disease, and be directly involved in their eradication.

3. The Institutions of the Health System Must Be Changed
The health care system should be structured in a manner in which the equally valuable contributions of all health care workers in recognized. Both the public and health care workers should have a direct say in resource allocation and in determining the setting in which health care is provided.

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to-one education), education to reduce fear of liability, removal of perverse financial disincentives, and addition of administrative disincentives for utilization. "Market research" concerning the motivation for physician clinical activities (thus providing clues how these activities can be modified to conform with evidence regarding effectiveness) is likely to be necessary.

Laboratories

Currently private laboratories spend considerable resources selling their services to physicians and giving physicians incentives to use their laboratory. They also make a large profit. This is all wasteful. Concentration of laboratory services in public facilities would save resources.

Licensing of health technologies

Currently, pharmaceutical products are not licensed until the company has demonstrated that the product does more good than harm. Similar licensing procedures for diagnostic and surgical technologies should be instituted. The criterion for funding would the demonstration of patient benefit.

Restriction of funding for unproven procedures

Consideration should be given to withdrawing funding for medical acts in which there is major doubt about their doing more good than harm.

The Hospitals Act

The revision of the Hospitals Act should include provision for increasing democratization of hospital boards. Hospital boards should then be appropriately charged with obtaining evidence regarding the effectiveness of hospital procedures and with making cost-effective decisions regarding resource allocation. Debates and decisions of the board must be open to public scrutiny.

District Health Councils

District Health Councils could be made more fiscally responsible and democratic. They could then be appropriately charged with obtaining evidence regarding the effectiveness of health resource allocations and with making cost-effective decisions regarding resource allocation. Debates and decisions of the Council must be open to public scrutiny.

Physician payments

Alternative payment mechanisms of physician payments should be encouraged, and evidence of the effects of alternative strategies on health costs and outcomes, and physicians satisfaction should be collected.

While the fee-for-service system continues there should be more rigorous monitoring of physician billing. It is possible that there is currently a large degree of inappropriate and perhaps even fraudulent billing. More careful monitoring could uncover this billing and add to the efficiency of the system.

Provincial drug programs

Currently, provincial governments typically pay retail prices for drugs. There is no reason for this to be the case. The government should enter into tough negotiations with the pharmaceutical industry to obtain the lowest price for drugs paid for by provincial plans.▼

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SYMPTOM, DIAGNOSIS, PROGNOSIS, THERAPY

Some things are too engrained to forget. Perhaps as a physician I can start with this framework.

Symptom One: Sometimes one sees articles written by MRG members, or MRG members being quoted in the media, stating positions which are fully in accord with MRG policy, and yet with no reference to the fact that they are members of the MRG. Why? If we reject the possibility that they fear the repercussions of being openly identified as members of the MRG, then one has to ask if they think that their MRG affiliation is irrelevant. Are expressed views more relevant and socially useful when not identified as the view of the MRG? If so, why is this? Has our role been superseded by other organisations? If so, which of these upholds our founding principles?

Symptom Two: Why has the MRG failed to loudly, openly, and repeatedly condemn the cutbacks going on in the narrow curative world of medicine? These include layoffs in hospitals, or "down- sizing" of hospitals, as is currently occurring. Do we agree with this "down-sizing"? Are we veering to the point of view of "Prevention Good, Cure Bad", as Orwell would say? Is it then right that patients are waiting inordinate time in Emergency rooms awaiting admissions — at least outside of Toronto?

Or indeed, why has the MRG not been speaking out on the cutbacks in the large big world? These include the increasingly apparent determination to "roll back" wages (read living standards), allow increasing poverty, allow unemployment to rise, allow relief payments and the social net to be steadily eroded. I cannot accept that these things are outside the MRG mandate or that we in the MRG do not know anything about these other issues. If we as physicians don't, we damn well should.

Could the fact that these actions are performed by an NDP, government have anything to do with it? In the writer's view, the NDP are social democrats performing the unpleasant duties that a capitalist class is unable otherwise to achieve. By this means the capitalists can pass their policies by an increasingly pressed and militant working class. (P.S. Test question: Does the word capitalist make you feel unhappy, is this too old-fashioned now?).

Symptom Three: Why do the most prominent public activities of the MRG seem to be south of the border, in the U.S.A., defending the Canadian system, warts and all? Be assured that this complaint has nothing to do with denying the manifest superiority of the Canadian system to that of the U.S.A.. Nor can the warm glow of comradeship be denied. This glow emerges when one defends the Canadian system against the Republicans and rednecks in the U.S., to the cheers of the U.S. population. But it sure as hell is easier selling Canada south of the border, than it is slogging uphill against the NDP, Tories, and Liberals.

Probably better for your career as well.

There is at least one relation of U.S. battles to those in Canada. This has to do with how the struggle over "managed competition" in the U.S.A. will spill over to the Canadian side. Particularly in the climate following NAFTA, and the merging of capitals (that's money and power, not Ottawa, Washington and Mexico City). But the MRG is not discussing these broader dimensions.

Symptom Four: Why are we so indistinguishable from what the OMA has to say, on just about anything? This even includes salary. I particularly sense this when fees for the MRG are discussed at General Meetings! I do feel so sad that the membership of the MRG are so hard up that they are worried about the fees for the MRG.

Blimey, why don't we just join the OMA and CPHA? The curists (very few of us it seems) would join the OMA, and the really preventive, progressive and r-r-revolutionary would join the CPHA.

Symptom Five : Why do we still wish to keep ourselves professionally virginally pure and remain only a physicians group? The answer I've heard all these years, is that: "Physicians are what we are, that is where we derive our credibility from, that is what we can speak authoritatively about." Yes well. Do we then not believe in a democratic structure that includes other health care professionals?

Ah, I see, we tolerate them in our Founding Principles but not actually within our organisation?

DIFFERENTIAL DIAGNOSIS:

Since I joined the MRG, I've heard a few reasons for the failings of the organisation. These include professional obligations, family pressures, ageing, weariness, the passing of the 60s, the necessity to get more wages, the summer cottage schedule, the wonderful community spirit of the Canadians making the class struggle unnecessary, plus variations on the Shavian view that "a young person has to be socialist but that an old person being so is stupid" etc. and all sorts of other bullshit.

OTHER DIFFERENTIAL DIAGNOSES:

i) Political cowardice.

This seems to be understood as a variation of: "Being non-partisan means not saying you are progressive". And Heavens to Betsy! Certainly not saying you are socialist, excuse me while I cross myself!

The line generally goes something like this: Physicians and the population will not buy radical nonsense; talk of tax hikes for the rich is not something we should get into; we should be strictly medical. Perhaps we can convince the best elements of the medical profession to engage in cost effectiveness studies; and persuade the population not to eat hamburgers whilst simultaneously running 30 blocks a day; and that is our role.

Besides we are non-sectarian. We cannot attack any party, particularly when they're basically on our side but have such a tough time with all the reactionaries out there. And finally, "Golly, Times Are Tough".

In my view, there is a difference between non-sectarianism and pusillanimity. The French United Front Government in the 1930s soon found out that it does not pay to always be non-critical to your political "allies" and foes, purely in order to maintain an alliance.

ii) Ostrich behaviour.

By now we are probably all clear that we are in a (capitalist) recession. How likely is it that any government will free the resources which new developments such as prevention will necessitate, without significant cutting of curative services? I argued a long time ago in this publication that both prevention and cu-

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rative services were needed. And furthermore that true prevention is not cheap, necessitating a major attack on corporate profits (food, car and road, tobacco, drugs etc).

Where has the Government really taken on prevention of tobacco smoking? What about the health effects of unemployment and alienation (Now there's an "old-fashioned" word), or is that not prevention but politics? Those that cheer "caps" on Ontario health spending of less than 2% per year could perhaps tell me how much of that saving has gone into prevention, and how much cost there may have been on stress and unemployment related illness from down sizing. Perhaps I should emphasise that I do not advocate ineffective and unnecessary curative spending. But I know my stress level when I am on call and I cannot get a bed that is needed for a sick infant.

I do not believe that our natural allies are the health economists, the academics, and a cost cutting government that refuses to even discuss taxing the rich. After all many of the academics and health economists have either already agreed with some of our basic concepts, or we learnt these from them. In any case they are in with the OMA, whose essential terms of reference they share. They after all do not mean to have a radical redefinition of society and health it would appear.

Our natural allies are, in my opinion, the workers at the CAW plant in St. Catharines who see through the smoothities of Raeism. They are the Ontario Health Coalition, which has been aided greatly by OPSEU, and other trade unions. They are John Clark and the various Coalitions Against Poverty.

I wonder whether we would not conserve energy and produce better results by being a specialised branch of a broader group? Or are we just as elitist as most docs, and do not want a broader group?

iii) Economic Ignorance

Does the MRG know that there is a ruling class? Does the MRG understand that The Deficit is not *"Our Deficit"*? Does the MRG understand what the profit motive does to warp production for society? What noises did the MRG make about the loss of the generic drugs industry?

The constraints of capital in the 20th Century to make profit are evident. What implications does this current crisis of capital have to the: "Political Determinants of Health" which our founding principles refer to? It seems to me that the MRG is not even coming close to discussing these issues.

PROGNOSIS:

Without change, the pace of events will leave the MRG behind. The Labour movement will dispense with us. The health economists do not want us, and the NDP Government is in bed with the OMA. It was once suggested at a general meeting discussion on navel gazing in the MRG, that it was important to keep the MRG alive until "the moment that it needs to swing into public action".

Exactly when will that moment be? The Emergency room at my hospital has become a ward for sick infants and children, because of the lack of paediatric beds. I will not even discuss the situation for adults, not being involved in their care, other than to say it is common to be nursed there awaiting a bed for up to 48 hours.

Proposed Therapy or Therapies:

1. A halt to the peace front with the welfare and health slashers of the NDP. Immediately and PRN.

2. Consider ways of having a more cohesive united front with other progressive organizations; perhaps even dissolving ourselves into the Ontario Health Coalition as a self-contained unit of it.

To end, I should add a disclaimer: these are my own personal views, not those of the MRG Steering Committee. These personal views of mine may or may not be agreeable to the membership. But in all fairness to the number of nurses being laid off, the workers on unemployment lines, the patients sitting in the ER, they should be discussed by an organisation whose Founding Principles includes the words: *We recognize the social and political determinants of health.*▼

Pharmacists' skills wasted

I am a little late getting to the December 1992 issue of *Medical Reform*, but I am delighted to learn of the revival of the Ontario Health Coalition.

My concern is with the "greater role of non-physicians", which the OHC (and the MRG) say they are committed to, and in particular the role of pharmacists.

To put it starkly, unless pharmacists work up to the level of their expertise, then we should stop training them to that level.

The reasons are many why we do not use pharmacists as the drug-experts that they are trained to be. Many of the reasons are generated by pharmacists and their concepts of survival in a commercial rather than a health care world, some by physicians, some by governments, and some by drug manufacturers.

That they do not live up to their training, or enjoy a useful health care image, is obvious from the list of participants at the Canadian Health Coalition's November 25-26 round-table, "The Road Less Travelled". Although "pharmacists are the only health care professionals who are *specifically trained* to provide the proper medication to the patients and to ensure they get the maximum benefit from their drugs," and although the cornerstone of modern health care is drugs, and although drugs are the only reason for pharmacists' existence, no pharmacist was present at the round-table.

My concern about all this goes back a long way, actually 1959 when I began to think out a better way for me to be more publicly responsible than as scooper of ice cream cones. What happened is another story, but eventually, after hitting my head against many brick walls, I became convinced that only an aware public would provide enough impetus to make the necessary changes to the way we distribute medicines.▼

John Hill
Consultant
Drug Use Management

Doctors, drug companies still blur guidelines

CMA's code of ethical conduct faces revision after only two years

BY STEVEN RAUCHMAN

OTTAWA – The Canadian Medical Association's (CMA) ethical guidelines on physician relations with the drug industry are being revised for the first time since they appeared in 1991.

The discussion paper "Physicians and the Pharmaceutical Industry" gives primary consideration to the still-blurred line between educational sponsorship by drug companies and advertising.

It also addresses the special vulnerability of medical students, interns and residents to the blandishments of industry through continuing medical education activities.

The original CMA guidelines were sound and used as a foundation for refinement, said Dr. John Williams (PhD), a bioethicist who is director of the CMA's department of ethics and legal affairs.

"In general there was substantial general agreement with the guidelines. The first document was perhaps uncertain in some places, and experimental in others. So we thought that, in looking back with some experience, it might be improved upon in some ways."

There has been reluctance from both the drug companies and doctors to co-operate fully with the first set of guidelines, since their intent is to change the relationship between doctors and the drug companies. Such patterns and habits are difficult to break.

"Compliance is something that's coming slowly," said Dr. Williams. "Some pharmaceutical companies are still offering things to the physicians that are contrary to the guidelines, and some physicians are still accepting them. But the number of these violations do seem to be diminishing substantially. There's no way of officially keeping track, but on anecdotal evidence we have from physician members of committees, the number of gadgets and freebies and so on is going down a lot, and the offers of sumptuous accommodation at resort hotels and so on is diminishing.

"We knew all along that this would be a gradual process that would take a while to get going. But we're working closely with the Pharmaceutical Manufacturers Association, which has its own code of marketing practices, and they do enforce it. There's substantial agreement between that document and the CMA guidelines," which he said is crucial, since the mutual effort between medicine and business is "to make sure that these relationships really are aboveboard.

"Ethical standards are generally higher than legal requirements," Dr. Williams said. "And there's some confusion within the medical profession, even with guidelines such as these," as to the relationship between ethics and law—and the parameters of choice when making personal decisions.

The revised guidelines will request more directly that physicians be aware of their individual moral responsibility "to inform their consciences in making decisions about whether relationships with industry are appropriate or inappropriate, on a day-to-day basis. Laws, rules, regulations are an attempt to set forth ethical standards for all sorts of activities. But realizing that individual situations differ a great deal," he said, physicians will be requested to be more aware of the choices they make. "The guidelines are intended to help people make these decisions."

Product identification in conjunction with drug companies funding CME activities is also likely to receive more stringent treatment in the revised guidelines as well, Dr. Williams said.

"The long-standing practice of companies putting on events which are really designed to promote specific drugs" still continues, he said, with events being "held with a speaker who will speak about that drug and nothing else. There's a dinner and things given out in the name of education. But it's really product promotion.

"Advertising is going to go on forever. It's apart of our culture. Doctors are the target of drug company advertising, but I think the intention here will be to make a cleaner separation between promotional and education activities."

Influences

Developing principles and practices that apply to medical students, residents and interns is a third area under consideration to be amended. Doctors-in-training have a particular need to be aware of such influences, Dr. Williams said, because of their vulnerability and newness to the profession.

Physicians-in-training have been amply apprised by industry and while they receive funding for conferences and the like from pharmaceutical companies, young doctors haven't been made equally mindful that "they should follow the same procedures followed by the experienced members of the medical profession." He added, that in the future, medical schools in the might consider incorporating the CMA guidelines for dealing with the drug industry as part of the medical curricula.

The process of revision began in the fall of last year, when notices were sent to about 150 groups and individuals, including medical associations, health organizations, industry groups, and deans and directors of continuing medical education at medical schools. Jan. 15 was the deadline for responses to this portion of the revising process.

"We know that we didn't fulfill the suggestions of everybody, because many times they were contradictory to each other," Dr. Williams said. "So we sorted them out and did what we thought best in terms of the spirit of the guidelines, and practicalities. So this (next) draft will probably receive more comment, since I think some groups were waiting to see what was going to be proposed."

The proposed changes will be sent out to the same nationwide advisory groups and individuals, who are to respond by April 15. The changes will then be collated and ratified by the department of ethics and legal affairs, and given executive consideration by the CMA's board of directors.

Finally it will be up to the general council, which meets Aug. 22-27 in Calgary, to give its final stamp of approval to the revised guidelines—which will likely draw yet tighter the free rein once accorded the drug industry.

McMaster U. sets its own policy for residents

HAMILTON – While the Canadian Medical Association (CMA) revises its guidelines for doctors' dealings with drug companies, McMaster University here has put in place its own policies to help residents maintain distance from the influences of drug companies.

The policies are likely to be adopted, in some form, by other medical schools across the country.

Instituted by McMaster's Department of Medicine Residency Program, the guidelines specify:

- the residency program should in no way invite non-educational largesse from industry coming to students or faculty;
- that representatives of the pharmaceutical industry should not be allowed to attend the Department of Medicine Residency Program's educational events and;
- that funding may be sought by the department from the pharmaceutical industry for self-generated educational activities, but any acknowledgment of drug company contributions shouldn't be seen as advertising.

Further, industry may sponsor an event or activity that the residency program views as an educational priority, but it cannot participate in its planning, and cannot influence the content of the event.

Nor may a company demand that any of its own material be distributed, or that any of its representatives be present. If funding is contingent on any of these conditions, the residency program must decline support.

The assumption underlying these tough measures, instituted about 18 months ago, "is that the program should not be party to residents receiving gifts from the industry, and that the industry should not be able to buy access to the residents," said Dr. Gordon Guyatt, program director of the Internal Residency Program at McMaster.

"It's worded in a little nicer way, but that's the gist of it."

The guidelines are a reaction to the aggressive marketing strategies used by the drug industry during the late and mid 80s.

"There were major problems in that among the four teaching hospitals there was extreme proliferation of what were called 'drug lunches' in which the pharmaceutical industry took responsibility for noon-hour teaching sessions for the residents, often bringing along a film, and in all cases bringing along lunch for the residents," said Dr. Guyatt.

Phone calls

"In addition there were phone calls to the senior residents from the pharmaceutical industry offering them this, that and the other thing, and looking for opportunities to interact with them. In my mind this was a very unsatisfactory state of affairs."

It was felt McMaster had no guidelines and many different standards were being use. "There were questions arising over and over again as to the appropriateness of what we should accept and let happen," he said. "There were extremely different ways that people had of handling their interactions with the pharmaceutical industry."

The "drug" lunches have been stopped and the new guidelines put in place, but there is still debate among faculty and students about what should be acceptable. Dr. Guyatt, who is a professor in both the Departments of Medicine and of Clinical Epidemiology and Biostatistics, said many considered it acceptable to take drug-company largesse. Some faculty physicians had taken paid holidays sponsored by the industry and saw little wrong with the "drug" lunches.

The pharmaceutical industry is seeking other ways to approach residents that do not infringe on McMaster's guidelines. Chief among these is the tactic of "contacting residents in off-hours, and taking residents out to dinner. In other words, they've shifted their bribery to personal bribery of residents because it occurs outside the boundaries of the program," said the doctor.

"We don't have the authority to be responsible for the personal ethical behavior of our residents. What we can do is create a model and discuss it; but as soon as they step out of the program, what they have to pay attention to is the CMA guidelines for the personal behavior of all physicians."

Drug companies can continue to support events at McMaster—and receive due credit for their support—and submit information or products to directors of clinical teaching units for teaching purposes.

The McMaster medical faculty is also working on teaching more about pharmaceuticals and their properties in courses on internal medicine. Discussions about drugs have become a more integral part of the education program, which gives pharmaceuticals a prominent profile, but from a different direction.

"The new emphasis is on using the medical literature to make clinical decisions, and understanding the strength of evidence," said Dr. Guyatt. It also emphasizes the importance of studies done on "human beings that demonstrate clinically important effects."

The emphasis on epidemiological evidence of efficacy will help remove any concern that doctors receive most of their information about drugs from drug companies.

In early February, Dr. Guyatt presented McMaster's principles of industry relations to a meeting of the Canadian Association of Program Directors of Internal Medicine. The representatives of the internal medicine programs in the 16 medical schools across the country agreed to take the McMaster guidelines back to their home campuses, gauge reaction to the guidelines and then develop a national framework on medical school/drug company interaction upon which individual schools could develop their own approaches.

Hardball tactics

Judging by the response to date, McMaster's continuing medical education (CME) programs are likely to be supported more frequently by a fewer number of pharmaceutical companies, since some companies have been put off by what they perceive as hardball tactics.

Still, Dr. Guyatt sees reason for optimism since, he feels, "I think they're all going to come around, because they're all going to have to. I think clearly the milieu is changing, and some companies will be slower to adapt and some a bit quicker.

"So at the moment we're seen as an outlier in Canada, and indeed we're the first to take such rigorous guidelines, but it's clear that everybody's moving in that direction, as evidenced by the reactions of the other program directors. The industry I think will have to face that this is not the work of Wild Man Guyatt. This is in fact the direction in which people's thinking is moving."

Canadian Health Officials Testify in Montpelier on Benefits of Single-Payer System

By Ross Sneyd

THE ASSOCIATED PRESS

MONTPELIER - Advocates of a Canadian style health care system stepped up their campaign for its adoption in Vermont on Friday with a series of high-profile meetings featuring health officials from Ontario.

Rep. Bernard Sanders, perhaps the biggest promoter of what's known as a single-payer insurance system organized the sessions with legislative committees and the Vermont Health Care Authority.

Seven health care professionals from Ontario — ranging from a hospital president to the administrator of the province's health insurance system — pressed the case for single-payer.

"There are a lot of economics of scale, said Joan Sproule, a fiscal director in Ontario's Health Ministry. "The efficiencies in a system of single payer are absolutely phenomenal."

Under that plan, which has been in place throughout Canada for nearly two decades, hundreds of private health insurance companies are replaced by a single government-run insurer.

The Canadians cited a ream of statistics that they said show their country provides better health care more cheaply and ensures that every citizen has access too it.

And they said the sole reason for their cheap but quality health care was the single-payer system.

"It provides coordinated services which make the most efficient and appropriate use of the health care system," said Wendy Goodine, president of the Nurse Practitioners Association for Ontario.

The system that the Ontario delegation described is very much like the ideal that the Legislature has charged the Health Care Authority with devising. It provides coverage to every resident of the province, it is easily accessible no matter where someone lives and it controls costs through a global budget.

The difference is in the way it is funded. The provincial government raises money through taxes, sets a province-wide spending limit, or a global budget, and then distributes the money.

In Vermont, the Health Care Authority is drawing up two plans, one based on the Canadian style single-payer concept and another that would retain a number of insurance companies but that would be much more closely regulated.

Authority member Paul Harrington said the goals on the Ontario system were very close to what Vermont wants to achieve.

"In many regards, I think you're preaching to the choir," he said. "We are seeking to achieve what you have obtained in universal access."

But whether a single-payer plan is the way to gain universal access is a question that will have to be settled by the Legislature, he said. Authority members were more interested in the mechanics of the Canadian system, such as how global budgets were set, how patients in rural areas obtain the same level of care as those in cities are other issues.

Dr. Haresh Kirpalani, a pediatrics researcher at McMaster University in Hamilton, Ontario, said Canada was far from solving all of the problems in health care. "Canada is not utopia," he said.

But there also are many misconceptions in the United States, he said, about shortcomings in the Canadian system, weaknesses that "pale in comparison to the problems in the States," Kirpalani said.

"Is there rationing? There's no question about it," he said. "But it's a misnomer that there is no rationing in the States. It occurs through your wallets."

From the Rutland Daily Herald, March 27, 1993 ▼

Marketing health care to Americans

I recently represented the Medical Reform Group on a television program produced by a local television station in London, Ontario. The program raised the issue of whether three local hospitals should start to aggressively market their services to Americans, hoping to charge "premium" prices and make a profit.

The other participants in the debate were the President of the University Hospitals, an aggressive advocate of the marketing scheme, and the head of the local District Health Council, who was ambivalent about it.

The Hospital President argued that no more money could be expected from the government, that hospitals must develop innovative strategies for dealing with the financial crunch, and that attracting Americans would prevent layoffs in the hospital and provide resources for improving care for Canadians.

I argued strongly against the idea. I reminded viewers that the problem was funding constraints on hospitals precipitated by reduced transfer payments to the provinces from the federal government. I argued that we should not take a stance of helplessness with respect to government funding of health care. If we want to maintain a universal, high-quality system, we must pressure the federal government to reverse the trend of reducing transfer payments.

I also argued that the proposal represented a first step toward a two-tiered system: Americans will be allowed to jump the queue on the basis of their cash outlay. The next "innovative" solution to the funding crisis that the hospitals would suggest, I speculated, would be to ask Canadians to pay out of pocket for their health care, and provide superior services to those who complied. The president denied that Canadians would be waiting longer because of the American presence, and that indeed Americans would get no preferential treatment in terms of their waiting times. This would presumably be accomplished by expanding services.

While I remained sceptical of the President's contention about the lack of preferential treatment for the Americans, and the absence of adverse impact on care for Canadians, I stressed that the primary issue was philosophical. Health care, I argued, should not be treated as a saleable commodity, from which we can make a profit. By treating it that way for citizens of other countries, we open the door to treating it that way for Canadians.

The provincial Minister of Health, after some equivocation, has stated that she will not support Canadian hospitals catering to American patients. This is certain to be simply one round in a series of battles of whether Canadian will respond to the fiscal crisis in funding health and social programs by moving back to an American-style two-tiered health care system.▼

Gord Guyatt

News Briefs

New doctors hit

The Ontario government has moved to prevent new physicians from entering practice in the province's urban centres. Physicians who set up a practice in an area which is considered to have an over-supply of doctors will only be paid 25 per cent of the normal fee schedule. Since overhead costs are nearly always greater than 25 per cent of billings, this will effectively prevent any new physician from setting up practice in an urban area. The government says the move is designed to increase the number of physicians in under-serviced rural and remote areas of the province, while curbing the over-supply of doctors in cities. However, the way the government is moving to achieve these goals have been strongly criticized as unfair and arbitrary.

Enrollment cut at medical schools

Enrollments at the University of Toronto's medical school are being cut by 30 per cent. Only 177 new students will be enrolled this fall, rather than the usual 252. The cuts are part of a national effort agreed on by provincial ministers of health. Other cuts are taking place in medical schools in Alberta and Manitoba. Enrollments in other provinces, and in Ontario's four other medical schools, are being frozen. According to Michael Decter, Ontario's deputy minister of health, there are too many doctors in Ontario and in Canada. "Studies have shown that each new doctor that goes into practice costs us an average of $500,000 a year, when you consider what they bill, all the lab tests they order and hospital services that result." A ministry statement said that the number of physicians rose by 38 per cent from 1981 to 1991, while the population rose 12 per cent. Over the same period of time, health insurance payments to physicians in Canada went up 128 per cent.

Billing limit eased for some

Some doctors in rural and remote parts of Ontario will get a partial break from the provincial government's billing restrictions. The government previously imposed a "cap" on physician billings at $400,000 per year. Billings above that amount are paid at two-thirds of the regular rate, and at only one-third of the rate for billings above $450,000. But under a new deal between the government and the OMA, specialists in under-serviced areas can apply for an exemption from that limit. The Ministry of Health estimates that between 30 and 50 physicians will qualify for the exemptions. Currently, doctors who move to such areas are exempt from the billing limit for four years while they set up their practices. The new deal would give specialists an additional two year exemption.

Speaking for the Medical Reform Group, Dr. Mimi Divinsky said that the exemption is only a bandaid solution to the problem of overburdened doctors. She said the exemption will not solve the problem of overworked doctors and will reward those who practice "revolving-door medicine". "Doctors who consistently bill higher than the limit are overworked and not able to spend the time needed with each patient", she said.

Cutbacks in Emergency

In an effort to cope with funding restrictions, some hospital emergency rooms will start sending certain types of patients back home instead of admitting them, the Ontario Hospital Association has announced. According to Beth Witney of the OHA, the measures will affect only those who don't really need to be admitted to hospital, such as elderly people with arthritis or problems with their medication. The measures are to be coupled with the use of quick response teams, usually headed by a nurse, which are supposed to follow up to make sure that patients' needs are taken care of and that they are able to cope at home on their own.

Birthing centres

The Ministry of Health has asked for proposals to set up three out-of-hospital birthing centres to be staffed by midwives. Licenses for the centres are expected to be issued by the beginning of 1994, and the centres are expected to be operational by the fall of 1994. Midwives in the centres are to be salaried. Midwives are expected to be fully licensed and funded in Ontario by the end of 1993, and three Ontario universities will be offering midwifery programs.

Meetings and Conferences

Ethical issues conference

The eleventh international King's College conference on Death, Dying, and Bereavement will focus on ethical issues in the care of the aged, the dying, and the bereaved. The conference will be **May 17 - 19** in London, Ontario. Contact King's College, 266 Epworth Avenue, London N6A 2M3, (519) 432-7946.

The bucks stops where?

The Centre for Health Economics and Policy Analysis (CHEPA) is sponsoring a conference on accountability in health and health care, titled "The Bucks Stops Where?", in Hamilton, **May 20 - 21**. Contact Lynda Marsh, CHEPA, 1200 Main Street West, Hamilton L8N 3Z5, (416) 567-7195.

Association of Ontario Health Centres

The annual meeting of the Association of Ontario Health Centres will be held in Mississauga on **June 2 - 5**. Contact Connie Patterson, Association of Ontario Health Centres, 5233 Dundas St. West, #403, Etobicoke, Ontario M9B 1A6, (416) 236-2539.

Law and Medicine

The Canadian Institute of Law and Medicine is holding its spring conference on **June 4** in Toronto. The theme of the conference will be Ontario's new laws on Consent to Treatment, Guardianship, and Advocacy. Contact the CILM at (416) 841-3771.

MRG Spring meeting

The Medical Reform Group's spring general meeting will be held on Thursday **June 10** at 7:30 p.m. at the Davenport-Perth Community Health Centre, 1900 Davenport Road, in Toronto. The theme of the meeting is "Ontario's NDP government: Part of the problem or part of the solution?" Dinner will be catered in, and will be from 6:30 to 7:30. If you want to eat dinner, please call (416) 588-9167 by Friday June 4.

MRG Steering Committee

The Medical Reform Group's Steering Committee next meets on Thursday **July 8** in Hamilton. MRG members are

invited to attend Steering Committee meetings to observe, take part, or to raise issues the MRG should be addressing. The Steering Committee meets monthly; meetings alternate between Hamilton and Toronto. For information on time and place, call (416) 588-9167.

Redressing the Imbalance

The Northern Health Human Resources Research Unit at Lakehead University is organizing and hosting an international conference for **October 21-24** in Thunder Bay, titled "Redressing the Imbalance: Health Human Resources in Rural and Northern Communities". Submissions are invited from those interested in health human resources and the problems associated with recruiting and retaining health professionals in rural and northern communities. For more information contact Connie Hartviksen, Research Associate, Redressing the Imbalance, c/o NHHRRU, Health Sciences North, Lakehead University, 955 Oliver Road, Thunder Bay, Ontario P7B 5E4, (807) 343-2135, fax: (807) 343-2014.

PUBLICATIONS

Partnerships in Long-Term Care

The Ontario Ministries of Health, Community and Social Services, and Citizenship, published a discussion paper in April titled "Partnerships in Long-Term Care: A New Way to Plan, Manage and Deliver Services and Community Support." Copies of the discussion paper, to which responses are being sought, are available from the District Health Councils.

Drug Reform

The Drug Programs Reform Secretariat has released a background paper on "Issues Related to Pharmaceutical Investment and Development". Available from the Drug Programs Reform Secretariat, 700 Bay Street, 3rd floor, Toronto, Ontario M5G 1Z6.

Sexual Abuse of Patients

The Ontario government has released a series of proposals in a paper on "Taking Action Against Sexual Abuse of Patients". Available from Professional Relations Branch, Ministry of Health, 7 Overlea Blvd., 5th floor, Toronto, Ontario M4H 1A8.

Ontario Health Survey

The Ministry of Health has published the "Ontario Health Survey 1990". The survey looks at how healthy Ontarions are, what health risks Ontarions take, how health care services are being used, and what can be done to achieve health.

Environment and Health

The Premier's Council on Health, Well-being and Social Justice has released a report titled "Our Environment, Our Health". The major sections of the report focus on healthy ecosystems, healthy communities, and healthy workplaces. Available from the Premier's Council, 1 Dundas Street West, 25 floor, Toronto, Ontario M7A 1Y7.