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 4 — October 1993

David Naylor to look at practice guidelines at MRG fall meeting

David Naylor, head of the Institute for Clinical Evaluative Studies, will be the featured speaker at the Medical Reform Group's fall general meeting.

His subject, Practice Guidelines, is one that is receiving a great deal of attention from a number of different directions.

Practice guidelines are favoured by those who want to see a health care system that provides effective health care to all without barriers. They are also being seized upon as a means by those who want to restrict medicare services and create a momentum for increasing privatization in the health care field.

The fall meeting will be an opportunity to hear an analysis of what rational practice guidelines are and how they can be used, as well as how they can be abused. A lively and thought-provoking is guaranteed.

The fall general meeting will be on **Thursday November 4** at the Davenport-Perth Community Health Centre, 1900 Davenport Road, Toronto. The meeting will begin at **precisely 6:50 p.m.**

Dinner will be available at the meeting, starting at 6 p.m. Registration is $10 with dinner; $5 without dinner. If you want dinner, please call 416-588-9167 to say you are coming (we need to know how many meals to order.)▼

U.S. health care businesses chasing profits into Canada

By David South

American-style private health care is slipping across the Canadian border under the noses of three provincial NDP governments, say researchers representing an association of health care workers.

Jackie Henwood and Colleen Fuller of the 7,500-member Health Sciences Association of British Columbia charge in a recent report that a combination of free trade and tightfisted government spending is undermining the universality of medicare and ushering in the beginnings of a two-tier system.

While the health care industry created more jobs than any other sector of the economy between 1984 and 1991, they point out, things have changed dramatically since the Canada-U.S. free trade agreement came into effect in 1989. Now much of this growth is clustering in the private sector.

And they expect that this trend will continue under the forthcoming North American Free Trade Agreement.

"NAFTA will accelerate trends towards a privatized, non-union and corporate dominated system of health care in Canada," says the report.

Chapter 14 of the Canada-U.S. Free Trade Agreement opened competition for health-care facilities management services to U.S. companies. Certain NAFTA provisions will bind all levels of government to consider for-profit health care companies on equal footing with public providers when bidding for services, and entitles them to compensation if they can prove to an arbitration board that they've been wronged.

"That represents a substantial encroachment on the democratic right of local, provincial and federal governments to make decisions," says Cathleen Connors, who chairs the Canadian Health Coalition, which includes labour activists, nurses, doctors and other health care-workers.

This, in combination with health care cutbacks — both federal and provincial — is resulting in service and job cuts, bed closures, increased drug costs and an increase in privatization, the report says.

In the area of home care, for example — visiting nurses, physiotherapists, homemakers and other services — private firms now take in close to half of all OHIP billings. Many of their clients pay out of their own pockets for services.

The Ontario ministry of health doesn't keep statistics on the private home health care sector in the province, but the Ontario Home Health Care Providers' Association, a trade group, estimates that private firms in the industry now employ 20,000 people. They also serve more than 100,000 Ontarions.

The industry is dominated by a small number of large firms, including Paramed, Comcare and Med+Care.

"It's a market situation," says Henwood. "If the services aren't available to people within the public sector, they will go outside of it.

"We've seen this in other countries like England, where they had a public system and now have a parallel private system. If you erode a system enough that people get pissed off, they are going to start to look for alternatives, and the people with the greatest liberty are those with money."

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Connors says that because the Canada Health Act only covers the provision of hospital and physician services, the principles of universality and comprehensiveness don't extend down to community-based services like home care.

The study also found that giant U.S. private health insurers are positioning themselves to reap profits in the fertile Canadian market.

Last April, Wisconsin-based American Medical Security Inc. announced it will begin offering American hospital insurance to Ontario residents, citing a demand in Canada to bypass lengthening waiting lists for medical treatment.

Giant U.S. west-coast insurer Kaiser Permanente declared in the March 1992 issue of Fortune magazine that they have targeted Canada as the next growth market. And American Express membership now offers the privilege of health insurance.

With private health care services sprouting up like spring weeds, says Henwood, provinces are placing yearly limits of the number of private services covered under the provincial health plans, thus preventing people shopping around for services, no matter what their income.

Sheila Corriveau, corporate relations coordinator at Toronto-based Dynacare, Canada's largest full-range private health care company — which operates labs, retirement homes, home-care services and consulting services — is enthusiastic about expansion plans, and says that removing patients from hospitals into their homes has been a boon for private health-care services.

"I think the health system will benefit, because what you are really doing is off-loading the cost from the public sector and from the treasury to private enterprise," says Harry Shapiro of Dynacare. "Private enterprise depends on its own ingenuity for survival and its own levels of efficiency."

But the advocates of the public system say the free-market option now looming is being ushered in by the very parties that Canadians have come to rely on to defend medicare.

Ontario's new health minister, Ruth Grier, however, denies her government is jeopardizing medicare.

"I want to disagree with that as profoundly as I can," she says, fidgeting with an ashtray during a recent interview. "Our government has reaffirmed its commitment to medicare. Over the last decade, under Conservative and Liberal governments, health care costs have increased in double-digit figures. The system would have collapsed at that rate of growth.

"I guess I haven't found a way of blaming free trade for failures of the health care system at this point," she says.

But critics say in the last year alone, Ontario's ministry of health has capped health coverage for travellers abroad, removed coverage for physical exams requested by employers, chopped hospital beds and cut back the number of drugs covered on the provincial drug plan.

Grier says that the government's vision relies on a new view of medical care seekers as consumers who are going to take more responsibility for their own health care.

"Government can't do it all," she says.

This article originally appeared in NOW Magazine.▼

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.

Time to renew your membership - Time to recruit new members

The arrival of fall means membership renewal time. If you are a member, you will find your renewal notice enclosed with this newsletter, for the year beginning October 1, 1993 and running through to September 30, 1994.

As the enclosed letter from membership co-ordinator Jim Sugiyama points out, these are "interesting" times for those concerned about the health care system.

Frighteningly interesting, in fact.

Decisions are being made which will fundamentally affect the shape of the health care system, and of society, for years to come.

It is vital that strong progressive voices be heard in the face of the regressive forces that threaten to engulf universal medicare in Canada. The Medical Reform Group has played, and must continue to play, a strong role in advocating progressive positions.

Our voice is only as strong as our membership, however. The MRG needs your membership renewal, and it needs its members to be participating as actively as possible in the affairs of the group and in taking our message to the medical profession and the public.

So, please write out your cheque and send it back as soon as possible. The fees for all existing categories of member remain unchanged. Please note however that we have recently added new fee categories for residents and interns and for retired physicians.

If you can afford to pay an additional Supporting Membership contribution, please do so. On our tight budget, the extra amounts donated by Supporting Members often mean the difference between being in the black, and being in the red.

Enclosed you will also find an MRG membership brochure. Please pass it on to a colleague and tell her/him about the MRG and its aims. More brochures are available for the asking if you can use them.▼

Marketing Health Care to Americans?

By Paul Huras

Recently I had the opportunity to read your Volume 13, Number 2 May 1993 edition of the *Medical Reform*. I congratulate you on an excellent edition and what is no doubt a consistently high quality newsletter.

I must, however, advise you of my displeasure with Dr. Gord Guyatt's representation of the *Inquiry* television program on BBS (Marketing Health Care To Americans).

Particularly, his reference to my ambivalence to the issue is most disturbing., Perhaps Dr. Guyatt was referring to the monitor's introductory stated perception of each participant's position. Listening to my comments, however, would not have left any doubt as to the fact that based on current rationale, I am against aggressive marketing of our health services to Americans.

My general position, to be clear, is that our health care system does not need additional money, but instead a more effective expenditure of the current allocation. The following, which include many of the comments I made during the televised debate, are issues and questions which I believe must be discussed and answered before justifying the pursuit of such marketing schemes:

1. Need for Additional Health Care Funds

Do we really require increase funding (private or public) for our health care system?

We spend:

- $2.0 M per hour in Ontario on health care;
- 1/3 of our provincial budget;
- some estimate as high as 30% can not be proven effective or efficacious;
- $400-500 M spent annually paid to doctors to treat the common cold;
- Canada spends more per person on health care than Sweden, Germany, The Netherlands, Japan, Australia, New Zealand and Britain (although most data does not provide for an apples and apples comparison); while our life expectancy and infant mortality compares equally or worse than these countries.
- Compared to other countries, our growth in spending, when adjusted for inflation and growth in GDP, is the highest in the world.

What is needed is strategic approaches to allocating resources to high priorities and evaluation of the need for older programs.

As well we need to find inefficiencies. Do we need a full array of support services in every single institution, especially in multi-hospital towns?

2. Threat to accessibility

- If Americans have access to our health care system, will Canadians have less access?
- If an American patient goes sour in an operating room and more resources are needed, will they be provided at the peril of a Canadian patient?

3. Opportunity costs

- What are the opportunity costs associated with providing care to an American market?
- Any money invested in this type of venture needs to be assessed from the perspective of what else it could have funded.
- Could this money generate higher revenues from other ventures (international consulting, occupational health services)?

4. Cost accounting

- Are all costs truly accounted for in determining pricing strategy and break even volume levels?
- Do we know the cost behaviour for those services to be marketed to the US?
- Are *all* variable costs identified (i.e. bed linen, sterilizing surgical tools, counseling)?
- Are *all* fixed costs identified (i.e. administration time to develop concept, case costing systems, computer, heating costs)?

We in Canada, are not very expert at costing our health care product.

5. Jobs

- Aggressive marketing to the US may create or maintain jobs, but for how long?
- We are not well experienced in Canada in selling and marketing health care.
- What happens if after the first year an enterprising US hospital develops a more price attractive opportunity for a US insurance company?
- Free trade will allow US hospitals to challenge Canadian hospitals on this approach.
- Do we undercut to stay in business thereby subsidizing US care with public funds?
- Do we try to keep staff in redundant positions?
- Do we recognize the false hope we created and hence lay people off?

6. Two-tiered health care

- Does marketing to the US create the potential for a two-tier system in Canada where the rich have better access to better care?
- Will US insurance companies accept the same waiting lists as Canadian patients?
- If not, will rich Canadians wanting shorter waiting periods buy insurance in the US and jump queue thus getting preferred access?
- Will Canadian doctors get paid US rates for treating US patients?
- Will the best Canadian doctors become focused on making their fees from US patients thereby leaving Canadians with less quality?

7. Education of Canadian physicians

- Will serving US patients perpetuate our imbalance in production of specialists to meet Canadian needs?
- In Canada, for example, is the balance of pediatrician graduates compared to geriatrician graduates consistent with the population's need?
- If marketing to the US causes Canadian medical schools to reflect US patients' demand compared to the Canadian population's need then are we not jeopardizing our care?

8. Slippery slope

- Is this the slippery slope?
- If we start where does it end?
- Can US insurance companies cross the border?
- Do we start to sell CT scans, lab services?
- Is capital construction aimed at building capacity for US patients?

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Marketing Health Care to the US
Continued from Page Three

These issues and questions reflect a definite opinion.

Reading your newsletter made me realize my philosophies on health care in Canada differ very little from that of the Medical Reform Group. Having sloughed me off as a professional who has no opinion is an affront to me as an individual who wishes to help reform the system.▼

Paul W. Huras
Executive Director,
Thames Valley District Health Council

Reply to Paul Huras

I would like to apologize to Paul Huras for misunderstanding his position. As he does in his letter to us, Mr. Huras, to a considerable extent, framed his opinions during the debate as questions or doubts about the policy of selling health services to Americans. I did not understand that he had his own very definite answers to the questions he was (it turns out rhetorically) posing.

I am very pleased that Paul Huras agrees with us that the answers to his key question: "Is this the slippery slope?" is affirmative. I look forward to working along side Mr. Huras to defend our universal health care system against the inroads of privatization.▼

— Gordon Guyatt

Who's Padding the Costs of Health Care?

By Ernie Lightman

So the politicians have finally discovered fraud among users of the Ontario Health Insurance Plan, and are now all energized to clean up the mess. An internal Health Ministry report has found that a great many ineligible people are using Ontario health-insurance cards, and Premier Bob Rae has declared that "no amount of fraud is acceptable."

Abuse of OHIP should undoubtedly be checked, as quickly as possible. But there is a risk in focusing only on the demand (consumer) side of the analysis. Improper or inappropriate OHIP billings by doctors also help inflate the health-care bill.

In Canada, let us remember, we do not have a system of "socialized" medical care, as the Americans are so fond of describing it. What we have is a private, profit-driven entrepreneurial model (the individual doctor) with guaranteed third-party payment (by government). And the fiscal accountability of the doctor is limited.

Doctors all too often consider billing investigations by OHIP as little more than a nuisance. The sanctions for those caught out usually amount to a slap on the wrist, perhaps an apology for the "misunderstanding" and repayment of the funds. Strictly from an economically rational point of view, the doctor is encouraged to cheat, since the risks are slight and the financial benefits substantial.

There are ways of dealing with this. One would require each consumer to sign an individual bill with his or her OHIP number imprinted on it, exactly as customers would in using a credit card to buy shoes from Eaton's. The symbolic effect would be to acknowledge that the health-care relationship is not one between a benevolent provider of services and a recipient, but a market exchange between sellers of services (doctors) and buyers (users/taxpayers). By signing the "bill," which would still be paid through OHIP, the buyers would be sanctioning payment for services received.

This bill would indicate the full cost of the service. It might thus impose some moral restraint on users, making them aware of the price of what they are "buying." More important, it might impose a similar moral restraint on doctors, who would have to show the consumer just how much the three-minute session is costing the taxpayers.

The credit-card analogy goes only so far, of course. Perhaps the real abuse of OHIP involves actions that are not illegal, but follow inevitably from a supplier-driven system with limited fiscal accountability.

In 1991-92 I constituted a one-person commission of inquiry, appointed by the Ontario government, into boarding houses and retirement homes in the province. I looked at residential settings in which limited amounts of care are provided by operators for a fee. The system is essentially unregulated, and includes luxury retirement homes for seniors as well as boarding/lodging homes, often for people with psychiatric histories.

The quality of care delivered to these residents, and its cost, were recurring issues. I was at one retirement home in the Toronto area on the doctor's weekly visiting day. The residents, mostly frail, were lined up in the corridor, waiting. The doctor would "visit" all 30 or 40 residents in a couple of hours, regardless of their individual need, and bill for that many home visits. The same practice occurs in many nursing homes.

Are these billings illegal? No. Does this reflect quality medical care, or assembly-line treatment? Does every resident of this rest home really need a cursory home visit from the doctor every week?

Doctors get off lightly, MRG says

By Gord Guyatt

On the day of the release of the agreement between the OMA and the Ontario government, I spoke on behalf of the MRG to an interviewer from CBC radio. The first point I made was that fairness dictated that doctors, who are the most highly paid group subject to the social contract, should take the biggest hit. The agreement, as reported at that time, suggested that physicians would be penalized less than many other workers in the public sector. Subsequent details, particularly physicians' opportunities to make up for any lost income by direct billing of patients for services that are going to be removed from OHIP, has confirmed that doctors, relative to other workers, have been spared.

The second point was that the policy of excluding physicians who had graduated from medical schools outside of Ontario is a completely inadequate alternative for a national physician resources policy. It is likely to elicit retaliatory responses from other provinces against graduates of Ontario schools. The final outcome will be a no more rational allocation of physicians, but restriction of physicians' mobility. This will accomplish nothing but increasing physician dissatisfaction.▼

I was contacted directly at one point by the OHIP billing unit in Kingston. It had a large number of requests for chest X-rays to be taken using a mobile unit; some doctor somewhere had signed off for 175 chest X-rays to be administered to all the residents in one building. The doctor, as gatekeeper to the system, was paid for authorizing this blanket procedure.

Again, the billing was not illegal. But instead of X-rays for particular individuals based on medical need, it was easier and far more lucrative for the doctor and home operator — but far more costly for the system — simply to zap everyone in the place.

My report estimated that there are some 47,500 vulnerable adults living in Ontario's rest homes. If each one of these receives only one unnecessary home visit from a doctor (or one unneeded prescription) each month, the waste can be conservatively estimated at more than $1-million a month. And rest homes, of course, are but a tiny part of the health-care universe.

So perhaps it is not unnecessary tattoo removals that are bleeding the health-care system dry. Perhaps the real problem is that responsibility for public-spending decisions has been given to private organizations such as the Ontario Medical Association and the College of Physicians and Surgeons, which have little or no public fiscal accountability.▼

Ernie Lightman is an economist at the University of Toronto.

This article appeared in the Globe and Mail, *August 29, 1993*

Write! Fax! Mail!

Do you want to react to something you've read in *Medical Reform*, or to something an MRG spokesperson said on the radio?

We encourage debate, and welcome your letters and articles. If you have a comment to make, or a subject you would like to write about, send it to us. Make *Medical Reform* your means of communicating your ideas about health care.

Submissions may be faxed to (416) 588-3765, or mailed to *Medical Reform*, P.O. Box 158, Station D, Toronto, Ontario M6P 3J8.▼

Response to Ernie Lightman

Solving Improper OHIP Billings

Ernie Lightman, in the *Globe* of August 21, correctly identifies physicians' inappropriate billing as a major cause of wasteful health care expenditures. However, his solution of requiring patients to sign a bill which the government health-insurance plan would then pay is completely inadequate.

The real culprit is our fee-for-service billing system in which doctors are reimbursed for every patient they see, every test they interpret, and every procedure they carry out. The system rewards doctors who deliver unnecessary care and penalizes those who take time with patients. Conscientious physicians who take time to provide careful explanations earn less than those who practice revolving-door medicine.

A better approach would be to reform the mechanism of physicians' reimbursement. Primary care physicians should receive a set amount for each patient under their care, no matter how many times they see the patient. This capitation-based system rewards physicians for practicing efficiently, and for keeping their patients healthy. A capitation-based system could also include community health centres staffed by salaried physicians. Once again, the salaried physician has no incentive to provide unnecessary services.

Capitation-based systems have worked in other countries, and they can work in Ontario. Until a capitation- or salary-based system is introduced, physicians will continue to yield to temptation and make inappropriate charges to the government payers.▼

Haresh Kirpalani, Gordon Guyatt

Get Active in Health Care Battle, Reform Group Urges

By Craig Sumi

Slowly, and behind the scenes, doctors, health care advocates, even medical students are pushing the provincial government for reform of the health care system.

But they say that for change to come, the public needs to get active.

"The government has to be dragged kicking and screaming into the arena if any reform is to be done," said Chris Jinot, a spokesman for McMaster University's Medical Reform Group. "More of a mass movement is going to be required to have any impact."

Mr. Jinot, a McMaster medical student, was one of the panelists last night at a forum on the future of Ontario's health care, put on by the McMaster Medical Student Council.

The theme was making the system more accessible, cost-effective and responsive to the needs of patients.

Lee Szaslosky of the Ontario Health Coalition echoed Mr. Jinot's call for more grassroots activism.

"The average person has become too content to allow expert groups, the doctors and bureaucrats, to do the talking," he said. "What we need is a big public base to press the government on the issues."

Mr. Jinot said most medical professionals agree the recent government trend towards "frenzied deficit reduction and cost cutting" threatens Canada's health care system.

He said there were smarter ways to trim costs than closing hospital beds, laying off staff and reducing the number of services covered under OHIP.

"This set of knee-jerk responses by provincial governments are running the risk of being detrimental to the health care system as we know it," Mr. Jinot said.

Among the reform ideas discussed last night were: giving more responsibility to district health councils at the expense of hospitals; establishing stricter guidelines on the use of high-tech screening equipment; and moving away from paying physicians on a fee-for-service basis.

Mr. Jinot called fee-for-service billing "a perverse financial incentive for doctors to provide unnecessary services."

He said if doctors were paid a flat per-patient fee and were given a set number of patients to look after, there would be more incentive to keep patients healthy.

"Fee for service is more focused on procedures than on health and prevention," he said.▼

This article originally appeared in the Hamilton Spectator, *September 15, 1993*

Looking at Canada's Health Care: It's 'Poised to Self-Destruct'

The following attack on the Canadian health care system appeared in the Wall Street Journal, *August 8, 1993*

By Jerome C. Arnett, Jr.

Sen. Paul Wellstone of Minnesota has recently introduced legislation that would establish a single-payer national health insurance plan. Health czar Hillary Rodham Clinton has denied interest in this. However, single-payer-boosters were heartened by a report published yesterday in the New England Journal of Medicine which suggests that a single-payer system would reduce bureaucracy in U.S. health care. Since Canada has had a single-payer system for over 20 years, there is much to learn from its experience.

According to Canadian health workers (and as reported in a growing number of Canadian news accounts), Canada's health system is lumbering toward disintegration and is poised to self-destruct. As the president of the Canadian Hospital Association noted in the June 10, Toronto *Globe and Mail*: "The sense of security that Canadians have in their health care system is very diminished. It's almost gone into retreat." Dr. Robert Macmillan, head of health insurance for the Ontario Ministry of Health. was quoted in a May issue of Forbes as saying: "All of Canada faces a lag in accessibility, particularly in highly sophisticated care."

Perhaps the most visible result of Canada's single-payer system has been the forced rationing of health care. A 1992 study by the Vancouver-based Fraser Institute found that patients had to wait, on average, five weeks just to see a specialist. Another 177,000 patients waited up to 14 weeks for surgical procedures.

In addition to availability of care, costs have escalated to $8,600 per year for a family of four, and have added substantially to Canada's staggering national debt: on a per capita basis, Canada's total combined federal and provincial budget deficit is nearly double that of the U.S.'s combined federal and state deficit.

Financing for Canada's health care scheme comes from three sources: general taxes, a payroll tax and deficit financing. Originally, the federal government paid 50% of the total cost and each province paid the remaining amount. The provinces which elected not to join the scheme were taxed for it anyway — Ontario lost $280 million (Canadian) the first year it did not join. In recent years, the federal government has progressively reduced its share of the cost to less than 30%. And because of insufficient funds, the provinces are cutting back even more on the availability of health care.

The direct costs of Canada's national health insurance are not as troublesome as the distortive effect they have on health care delivery. Health care facilities have been forced to cut back severely on their capital expenditures, thus depleting the availability of advanced medical equipment. As a result, many patients must seek advanced treatment elsewhere. According to a recent study reported in the New England Journal of Medicine, nearly one-third of Canada's doctors have sent patients outside the country for treatment during the last five years. About 10% of all British Columbia residents requiring cancer therapy have been sent to the U.S. In Toronto, because the government doesn't provide enough money for personnel, 3,000 beds have been removed from service, while thousands of patients are on waiting lists for admission.

Even where advanced equipment is available, bureaucratic absurdities prevent proper use. According to the April issue of "Fraser Forum," dogs at York Central Hospital in metropolitan Toronto were able to get CAT scans immediately while humans were put on a waiting list. The reason? Canadian patients are not allowed to pay for CAT scans, and the procedure costs too much to operate more than a few hours a day for nonpaying customers. Dog owners, on the other hand, were permitted to pay to use it. The user fees paid by the dog owners allowed the machine to operate longer, thus more human patients could be scanned. When this information was released, instead of considering user fees for humans, the Canadian government banned the test for dogs!

All this is taking its toll on Canada's medical practitioners. According to a recent poll by the Ontario Medical Association, 70% of the doctors in Ontario are very pessimistic about the near future of their profession; 50% of them have seriously considered relocating to the U.S. In fact, a large number of prominent Canadian academic physicians have already voted with their feet, and have moved to the U.S. out of frustration.

In 1987, a world-famous surgeon, Dr. Walter Bobechko, resigned as chairman of the orthopedic surgery department at Toronto's renowned Hospital for Sick Children, because he felt the government restricted patient care to the point of "negligence." He now heads the Humana Advanced Surgical Institute in Dallas, Texas, one of the largest medical corporations in the world. In fact, there are so many Canadian physicians in the Dallas area that they have considered starting their own organization.

For those who stay, a climate of hostility between health care providers and their bureaucratic pay masters now prevails. This past April, doctors in Winnipeg actually walked out on strike to demand improvement in wages and working conditions. They earned an average of $50,000 (Canadian) a year, which is less than the salary of the Premier's press secretary. And because of the deteriorating situation in Ontario, its government just last June proposed that it be allowed to exercise unprecedented powers to decide what services are medically necessary, how often patients may be seen and even how many doctors will be allowed to practice in the province.

Basic economics tells us that the law of supply and demand cannot be broken by the limited number of government (or HMO) managers who must make decisions for a nearly infinite number of individual citizens each time they have a new health care problem. Thus, under national health insurance, we can expect the continuing escalation of costs, a massive government bureaucracy micromanaging every aspect of health care, a lowering of the quality of medical care to the least common denominator, rationing and denial of care, the loss of civil liberties and freedom of choice by both patient and doctor, massive increases in taxation and possibly even nationwide doctor strikes.

Sen. Wellstone said recently:

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Canada's Single-payer health care scheme a singular success

The MRG Steering Committee wrote the following response to Jerome Arnett's attack on the Canadian health care system. The Wall Street Journal refused to publish the reply.

In the August 8 Wall Street Journal, Dr. Jerome Arnett presented a distorted picture of the Canadian health care system. As physicians with a combined experience of over 45 years working in family medicine, intensive care, and internal medicine in Canada, we would like to set the record straight.

Dr. Arnett quoted Canadian physicians and hospital administrators making remarks about how the Canadian health care system is in dire trouble. Understanding these comments requires some knowledge of their context. In the single-payer Canadian system, the government holds the purse strings, and negotiates on behalf of society with special interest groups, including physicians and hospital administrators. In contrast to American negotiations between a myriad of individual third-party payers and physician and hospital groups, the Canadian deliberations are conducted in the public eye.

This very visible negotiation requires that physicians and hospitals convince the public that they are entitled to a greater share of increasingly constrained public expenditures. How do they do this? They manufacture a sense of crisis. The required rhetorical flourishes in this public theatre should not confuse the external observer. Just because the boy is screaming wolf does not mean the wolf is really at the door.

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"Surely, with all our technology, creativity and good will, Americans can borrow from (other nations') experience and do equally well." Unfortunately, reality does not conform to the Senator's dream. Single-payer national health insurance based on the Canadian model would be a major disaster for the U.S.▼

Dr. Arnett is a West Virginia-based practicing physician. William E. Goodman, M.D., a Toronto-based physician, assisted in the preparation of this article.

So how should American observers obtain an accurate picture of what is happening in Canada? They should look at scientific surveys of Canadian physicians and (more important) Canadian patients, and compare them to what they find in similar surveys among Americans.

Despite the very real tensions created by attempts at cost control, both graduate physicians and physicians-in-training in Canada are extraordinarily satisfied with the system. For example, in one survey, 88% of Ontario physicians were either moderately satisfied or very satisfied with their ability to meet the needs and demands of patients. In another recent study, 79% of Canadian physicians were either "satisfied" or "very satisfied" with the quality of care they were able to provide, and 81% felt their patients had adequate access to specialist care. Only 18% of Canadian physicians-in-training think there is a serious problem with access to care in Canada, whereas 75% of U.S. physicians-in-training believe that Americans have a serious access problem.

Since cost containment pressures have put every country's health care system under siege, you will not find an overjoyed group of physicians anywhere. However, in contrast to what Dr. Arnett tells us, Canadian physicians have done well in maintaining their income and enjoy a mean net income of over $100,000. When you look at global ratings of satisfaction, Canadian physicians are consistently as or more satisfied than their American counterparts.

What's most important are the opinions, and the health, of Canadian patients. Writers like Dr. Arnett spend a great deal of time trying to convince Americans that Canadians have to put up with intolerable waits for quality care. They have the wrong audience: Canadians haven't heard yet. Ironically enough, more Americans than Canadians report not receiving needed care not only because of financial, but also non-financial barriers. In the most recent survey, 94% of Canadians rated the quality of care they received as good to excellent, and 85% said that they or their families had never had to wait an uncomfortable length of time for care. It doesn't take much insight to imagine what impoverished Americans would say if they had to answer such questions.

Canadians' reports of adequate care don't fit with Dr. Arnett's picture of endless waiting lists. That's because in reporting a single study of waiting lists, he doesn't mention the low response rates, distortions because of patients sitting on more than one waiting list, patients who will never go to surgery sitting on waiting lists, and he fails to distinguish urgent from elective procedures. In fact, a survey by the American General Accounting Office showed that there are no waiting lists at all for emergency procedures in Canada. Our own experience is that Canadian patients receive timely, high quality care, and have adequate access to high technology tests and procedures. The quality of Canadian medical care is reflected in Canadians' health. Canadians have a longer life expectancy and a 30% lower infant mortality than do Americans.

There are other distortions in Dr. Arnett's article. He presents the closure of Canadian hospital beds as a disaster, without mentioning that Canada has almost 40% more hospital beds per capita than the United States, and is moving to rationalize hospital care. He depicts a flood of dissatisfied Canadian physicians to the United States. We've already shown that rigorous surveys indicate that Canadian doctors are less dissatisfied than their American counterparts. In 1991, the last year for which we have data, more Americans physicians moved to Canada than the reverse. Many Canadian doctors who do go to the United States return to Canada, disgusted with the inequities in American health care.

The final issue is costs. Dr. Arnett cites rapid escalation of health costs in Canada. In fact, the single payer system has been extraordinarily successful at cost containment. Canada spends approximately 9% of its gross national product on health expenditure, while the United States spends over 13%. The biggest difference is the administrative savings in Canada, versus the administrative waste in the U.S..

What are the real differences between Canadian and American health care? Canadians have equal access to high-quality health care, as compared with the limited access to even basic primary care

Continued on Page Eight

Reply to Jerome Arnett, Jr.
Continued from Page Seven

among millions of uninsured and underinsured Americans. Canadians are far more satisfied with their health care system than are Americans, and they are healthier. Finally, the single-payer system allows Canadians to have these benefits while controlling expenditures. It's sad that Americans, repeatedly exposed to distorted presentations such as Dr. Arnett's, may not realize the enormous benefits of a universal-access, single-payer health care system.▼

Gordon Guyatt M.D., F.R.C.P.(C.)
Haresh Kirpalani, B.M., M.R.C.P.
Mimi Divinsky, M.D., C.C.F.P.
For the Medical Reform Group of Ontario

Hello Kingston!

The MRG office recently received two or three enquires from members in Kingston who want to meet other Kingston members. However, the MRG has a strict constitutional provision stipulating that no member's name and address can be released without their permission.

So.... If you are an MRG member in Kingston, and would like to meet with other Kingston members, please drop us a note saying it's OK to put other Kingston members in touch with you.▼

NDP government flailed at June meeting

At the Medical Reform Group's June General Meeting, the spotlight was on the actions of Ontario's NDP government in the health care field.

Haresh Kirpalani started the meeting off by describing a meeting he and other representatives of the Ontario Health Coalition (of which the MRG is a member) had with Karen Haslam, the Minister Without Portfolio With Responsibility for Health. The members of the OHC criticized the way the government was approaching cuts to health care spending, and its approach to the "social contract".

Haresh criticized the government for clearing the way for private interests to enter hospitals, such as the formula companies' contract with Women's College Hospital.

Haresh felt that the government was taking the advice of the Ontario Medical Association in targeting the weakest sector of the profession in attacking the incomes of new doctors. Why not lower the caps on the highest earners?, he asked.

According to Haresh, Ms Haslam began by defending the government's approach, but later acknowledged the validity of some of the criticisms.

Three days later, Ms Haslam resigned from the cabinet, citing disagreement with the social contract.

Ian Scott read a paper which he and some other residents at McMaster had written concerning the government's proposed measures regarding the payment of new doctors.

They agreed that some areas are under-serviced, and that spending on health care has to be a concern, but they questioned the way the government was going about tackling these problems.

The paper argued that under-serviced communities include not only rural areas, but also certain geographic, economic and social pockets in large urban centres. It went on to point to the fee-for-service system as something which "by its very nature encourages unnecessary utilization, prevents long term planning, and provides disincentives for providing quality patient care".

The paper stated that "a more equitable and reasonable solution would be to encourage the government to pursue limiting all doctors' incomes by supporting the system of capitation... This would also remove the disproportionate burden for correcting the health care system from young physicians who are to a greater degree today than ever before women and minorities."

In the discussion that followed, Gord Guyatt said that contrary to the way things are being portrayed, the health care budget is not burgeoning, it is fairly stable. In the last decade, the proportion of the GNP which goes to health care has gone from 8% to 9%. Gord said there is a world wide indoctrination project under way to make people believe that government spending on health and social services is out of control.

Susan Stock said that the Ontario NDP government has slashed money for preventive services. Cuts are being made with blunt instruments. In the occupational health area where she works, the vocational assessment unit has been cut. This work is now being done by private groups that are "incredibly anti-worker".

Michael Roberts said that some of the reforms that have been proposed by a number of provincial task forces in the past are now being implemented in a piecemeal fashion. The trouble is that in carrying out only some recommendations (the cost-saving ones) while putting others aside, new problems are being created. The example of moving mental health care into the community will be repeated — the recommendation to close institutional beds was implemented, but alternative facilities in the community were not created, with the result that patients were simply dumped onto the streets of Parkdale to fend for themselves.

Chris Jinot said that the government is not interested in real reform, it is only interested in cutting costs.

Vera Tarman said that the government is simply couching its cost-cutting measures in the language of reform.

Susan Stock said that government decisions are being made centrally, behind closed doors. Decentralization and democratization play no part in the government's approach. Rational planning is also not taking place: decisions are being made in an ad-hoc fashion.

Haresh Kirpalani said that the NDP government is responding to the reform

agenda in exactly the same way as the previous Liberal And Conservative governments did.

Russell Schachar said that bureaucratic mismanagement also plays a part. He gave an example: some hospitals have a budget to pay psychiatrists for work they do which cannot be billed to OHIP: e.g., meetings with Children's Aid workers, social service agencies, parents. Some hospitals were found not to be using this money for the purpose it was intended for, and the budget was supposed to take this allocation away from those hospitals. Instead the budget cut the allocation to all hospitals, including those who were using it properly. After protests, the Ministry eventually acknowledged that a mistake had been made, but said that it would take six months to reinstate the funding that had been cut overnight.

Haresh said that in addition to incompetence, there are also instances of deliberate sabotage by civil servants who don't like the NDP.

Don Woodside said that the world has changed for Canada since free trade was brought in. Our use of resources is unsustainable. But changes are not being brought in in an equitable manner. There is a case to be made for lowering incomes, those of physicians most of all.

Haresh said that the government is eroding universality. For example, drug benefits for the elderly are now being cut.

Gord said that the hysteria about the budget crisis softens people up for indiscriminate cuts and other harsh and inequitable measures. The line is that we are bankrupt and this justifies any nasty thing. This will be the basis of the attack on universality of health care and social programs. Gord said that we have to keep pointing out that as a society, we have more than enough resources to maintain universal health care.

Russell Schachar said that the changes that are being implemented are being made without bringing in needed structural changes to the health care system.

Chris Jinot added that they are being made without democratic input.

Susan Stock added that they are being made without addressing inefficiencies.

Rosana Pellizzari said that the debate is not being carried on in public. It is going on behind closed doors, among a select few. Then when they make a decision, they announce it all of a sudden, and there is no opportunity for input and discussion, because it is already a fait accompli. The JMC approach (Joint Management Committee of OMA and government representatives) is not working.

Gord said that the JMC has become a model: bi-lateral negotiations that excludes the public.

Haresh Kirpalani said that there are sub-groups of physicians who don't like the OMA and don't feel well represented by the OMA. For example, pediatricians, family physicians, interns and residents.

Gord Guyatt said that the MRG has been most effective when it has been in direct opposition to the OMA. The splits in the OMA are largely based on self-interest.

Rosana Pellizzari said that the health care system is controlled by physicians and the JMC continues to consolidate that.

Michael Roberts said that the Premier's Health Council has been gutted by the NDP.

Haresh Kirpalani said that the MRG should ally itself with organizations like the Ontario Health Coalition, trade unions, and consumer groups.

Gina Ogilvie said that in Quebec the formula for physician payment is much more sophisticated. If you are practising in Montreal, you make 80% of the fee schedule, with a few exceptions for under-serviced areas. In most places outside Montreal, you get 100% of the fee schedule. In some under-serviced areas, you get 110% of the fee schedule. Ontario's approach is crude and unsophisticated. Quebec now has about 160 community health centres.

Rosana Pellizzari said that the Ontario Ministry of Health sees community health centres as being intended for problem populations who you can't capitate. In rural communities where people don't move a lot, capitation makes a lot of sense.

Gord Guyatt said that the government is missing the point. Capitation, salary, CHCs are the way to go. Gord asked if we would support a differential fee structure for new physicians, or for all physicians?

Ian Scott said that he couldn't see a rationale for paying young physicians less.

Gord said that in most professions, you start low and work your way up in income.

Chris Jinot said that there should be a system of incentives to meet needs that are not being adequately met, e.g. AIDS care, under-serviced communities.

Russell said that we need an analysis of why people choose to practice in some areas and not in others. Economics are part of the reason, but not the only reason.

Gord suggested that our position, as we might state it publicly, should be along the following lines: The government has mismanaged health care reform. The JMC is a bad structure and a bad model. A more democratic system is needed. The government's current proposals regarding remuneration don't address the problem by any means. We need a fundamental restructuring of the health care system, especially alternative payment mechanisms. Young physicians should not be penalized in respect to these changes. Rather than penalize new physicians, we would support a lower cap on high billers. The demographics of new physicians are better. New doctors are more oriented to changed ways of practising.

There seemed to be agreement that this captured the sense of the meeting. The Steering Committee will base its response to the government's agenda on these positions.▼

NEWS BRIEFS

Computers to track prescriptions

The Ontario Ministry of Health has announced a computer network which will track patients' prescriptions. The stated purpose of the system is to prevent overmedication and drug interactions by giving pharmacists information on what drugs their customers are taking. The Ontario Drug System will connect about 2,500 pharmacists' computers to the health ministry. Green Shield Canada has been awarded the contract to set up and oversee the network in partnership with the Ministry of Health. Pharmacists are supposed to contact a patient's physician if the network identifies a problem. The Ministry of Health suggests that the network could be expanded to include other health care providers, including hospitals, private health insurers, and individual physicians. The plan drew support from Seniors'' groups, but was criticized by John Raufoy, a registered nurse who ran as an NDP candidate in the last provincial election. "This is an amazing invasion of privacy," he said. Raufoy said the computers will give too many pharmacists and doctors access to sensitive medical information. "The only reason for this is to save money, not lives," he said. "I can't believe my party is doing this. It's just one more example of Big Brother."

14 May 1993

Two-tier system advocated

The Fraser Institute, a right-wing think-tank with close ties to the Progressive Conservative government, is advocating that wealthy Canadians should be able to queue-jump if they pay the full cost of their medical treatment. According to Michael Walker, the executive director of the Fraser Institute, such an approach would help everyone because it would put more money into the system.

20 May 1993

Abortion bans don't work

Abortions are more common in countries that ban or restrict the procedure than in those where it is widely permitted, according to a report published by the International Planned Parenthood Federation. "It is a popular myth that abortion figures are highest in countries where abortion is most easily available," said Frances Perrow, a federation spokeswoman. According to the report, countries in Latin America which ban or restrict abortions have abortion rates of 30 to 60 for every 1,000 women, while in western Europe, the rate is about 14 abortions for every 1,000 women. The report suggested that countries with tough abortion laws also have few sex-education programs and generally limit the availability of contraceptives — increasing the number of unwanted pregnancies.

29 May, 1993

Setback for blood plant

A proposal by the Canadian Red Cross to build a blood fractionation plant in Canada received a setback after the Canadian Blood Agency rejected it. Currently Canadian plasma, collected from volunteer donors, is shipped to U.S. plants for fractionation. The Red Cross said that the $100-million Canadian plant would save taxpayers $400 million over a ten-year period and ensure self-sufficiency and safety of blood products. The Red Cross manages to collect only about 75 per cent of the plasma required to meet the needs of Canadian hospitals. The rest is bought in the United States and Europe. Canada's tainted-blood scandal, which saw more than 1,000 hemophiliacs and blood-transfusion patients infected with the AIDS virus, resulted in part because products made with contaminated blood from the United States were imported into Canada to meet shortages.

2 June 1993

New Thalidomide victims

Thalidomide, the sedative which was banned worldwide in 1962 after thousands of infants whose mothers had taken it were born without arms and legs, is producing a new group of deformed infants in Brazil. After being banned, Thalidomide was re-introduced in Brazil in 1966 as a treatment for leprosy only. Brazil's health ministry says that use of thalidomide is strictly monitored, but investigators have presented evidence that hundreds of deformed infants have been born and that medical officials have deliberately destroyed evidence to cover up many of the cases. Investigators found that drugstores were selling thalidomide without a prescription, and that many illiterate women taking it were unaware of the risks..

2 June 1993

Depo-Provera

The manufacturer of Depo Provera is appealing the federal health department's decision not to allow the drug to be marketed as a long-term contraceptive in Canada. Depo Provera, which is licensed as a cancer treatment in Canada, was given final approval as a contraceptive by the World Health Organization in June. Opponents of Depo Provera have repeatedly raised concerns about its long-term effects on women.

3 June 1993

HIV+ blood donors liable

The Supreme Court of Canada has ruled that people who knowingly donate HIV-infected blood can be prosecuted under existing laws. The court upheld the 1989 conviction of an Ottawa man who donated his blood to the Red Cross even though he knew he had tested positive for HIV and had been told not to donate blood. He began serving a 15-month jail sentence after the Supreme Court ruling.

5 June 1993

Hospitals advocate competition

The Canadian Hospital Association is calling for dramatic changes to the delivery of health care, including the introduction of market-style competition for hospital patients and the elimination of public financing for non-essential services. The association's Vision Project Report, released in June at the annual convention of the CHA, proposes that hospitals be forced to compete against each other for patients and public money. "We're talking about emulating the market system" said CHA president Carol Clemenhagen. "If some institutions are not as efficient as other institutions, they shouldn't be receiving public funds for that facility." The proposal is modelled in large part on reforms introduced in the British National Health Service by Margaret Thatcher's Conservative government several years ago. The CHA report calls for a fixed level of health care funding based on providing a core list of services. Services not on the core list would no longer be available unless patients paid privately, along the lines of the system adopted in the U.S. state of Oregon.

10 June 1993

Smoker denied surgery

Physicians in the United Kingdom triggered a public debate about medical ethics after the death of a patient who had been denied non-urgent heart bypass sur-

gery because he was a smoker. Dr. Christopher Ward, a Manchester cardiologist, said that "we're not penalizing smokers and not discriminating. The fact of the matter is the benefits they might get from having coronary bypass surgery are negated by the fact they continue to smoke." According to Dr. Ward, the evidence shows that non-smokers have a significantly greater chance of benefiting from bypass surgery. Others disagreed with the policy,. "My view is that once we accept an absolute bar to surgery for smokers, we... may well be on the slippery slope to withholding treatment for the unmotivated and unfit," wrote Dr. Matthew Shiu in the *British Medical Journal*. A smokers' rights group said that many others, including people infected with AIDS by drug use or sexual activity, alcoholics with liver disease, and athletes with sports injuries, are not denied treatment for conditions resulting from lifestyle choices. Dr. John Bailey, who opposes non-urgent surgery for smokers, said that likely clinical outcomes will have to be weighed more carefully as waiting lists for coronary surgery grow longer.

11 June 1993

Minister quits over "social contract"

Karen Haslam, Minister Without Portfolio for Health in the Ontario NDP government, resigned from the cabinet on June 14 in protest against the "social contract" legislation. "I firmly believe in the rights of free collective bargaining," Haslam said. "Any time you legislate an override on a collective agreement, I can't support that and I will vote against it," she said.

14 June 1993

Corporations want tax cuts

A group of 15 major corporations is proposing that companies should receive a rebate on their employer health tax if they offer health and fitness programs to their employees. The idea received endorsement from Ontario's deputy minister of health Michael Decter, who said "there is huge yardage to be gained, both for employers and for the society as a whole, in finding ways to contribute to employee health".

15 June 1993

Community care changes and fears

Patients' advocates are expressing concern that the Ontario government is rushing into a plan to shift psychiatric patients out of institutions before the services needed for community-based care are in place. The government announced in June that the number of psychiatric beds in Ontario are to be cut in half over the next 10 years. "We have to transform services that are fragmented so that we have a co-ordinated system," Health Minister Ruth Grier said: "Many of the people who have been occupying psychiatric beds for many years have not been getting treated and in fact can be more effectively treated in other ways."

"I applaud this but I'm scared," said June Beeby of the Ontario Friends of Schizophrenics. "You've got to have transitional money, and there isn't any. You've got to have the support services up and running. This will mean a gap of a few years, and they have already taken $45 million out of the mental-health envelope." She cited lengthy waiting lists for community-based therapy. "It sounds great in theory and God knows I'd like it to work, but I think it will be a disaster," she said. "If there are fewer beds for the very ill and no more money for mental health services over-all, it doesn't take a rocket scientist to figure out that this will mean more people living on the streets."

There are 370 community mental health programs in the province, providing case management, social rehabilitation, housing, vocational aid, psychogeriatric care, crisis intervention, day treatment and counselling. But studies show that there is a wide variation in services. "You can have 370 programs, but the vast majority of them wouldn't let a schizophrenic in the door," Ms Beeby said.

Ms Grier said in her announcement that she will not eliminate beds until community care is established, but Martha Gandier, co-ordinator of Toronto Psychiatric Survivors, a self-help group, is skeptical. She says that when the previous Progressive Conservative and Liberal governments closed institutions in the 1970s and 1980s, they made the same promises, but patients found themselves on the streets, isolated, without human contact, living in rooming houses in an endless cycle of poverty.

17 June 1993

Hospitals to close

Some Metro Toronto hospitals will have to close and others merge as the government tries to reform health care, Health Minister Ruth Grier has said. Grier says that she wants a plan for the closings by the end of the year.

17 June 1993

Non-profit homemakers planned

Health Minister Ruth Grier has announced that the province wants to replace private agencies supplying homemakers for the aged and handicapped under Ontario-funded programs with non-profit operations. "In these times of restraint, the government prefers to see tax dollars directed toward services for consumers, and workers' wages, rather than profit," Ms Grier said. The Ontario government estimates its funding supports about 15,000 homemakers, who provide the elderly and handicapped with help in shopping and household chores. The service makes it possible for people to remain in their homes rather than be placed in institutions. The province spends about $190 million annually on homemaker services. Private agencies provide nearly half of the publicly funded home care in the province.

26 June 1993

Tories eye user fees

The federal Progressive Conservative government is leaving the door open to the introduction of user fees for health care. Both Kim Campbell and Jean Charest suggested that user fees should be looked at as an option during their runs for the leadership of the party. Campbell later said that she personally didn't think user fees for "medically necessary" treatments were the best way to go, but didn't say she would lift a finger to stop provinces from introducing them. She also said that charging patients who go to a hospital for what is deemed to be a non-emergency condition that could have been handled by a clinic would not be a "user fee", since the hospital visit would not be considered a "medically necessary" service. This would not be a "user fee" said Campbell, "it's to discourage people from getting their services in an expensive place as opposed to a more cost-effective place."

In Tory code, "Never" and "Sacred Promise" mean "Not until after the election", while "Maybe" and "Wouldn't rule out" mean "Not until after the election".

26 June, 27 August 1993

Rural MDs form group

A group of rural MDs has formed the Society of Rural Physicians. Dr. David Fletcher was elected the first president of the organization, which is based in Mount Forest, Ontario. Among the is-

sues to be addressed by the group are a shortage of physicians in rural communities and the closing of small-town hospitals.

3 July 1993

Refugees to lose coverage

Ontario's NDP government is moving to remove OHIP coverage from refugee claimants, temporary workers, and foreign students. As many as 167,000 people could be affected, according to figures compiled by the Ontario Ministry of Health. At present, temporary Ontario residents are covered by OHIP in the same way that permanent residents are. Under the new legislation, they would lose that coverage and have to pay their own medical bills. Health Minister Ruth Grier said that it is the government's intention to restrict coverage to those who are considered permanent residents. The government has been pressing the federal government to pay for the health care of refugees.

3 July 1993

Drug money

The brand-name drug companies who benefitted from the Progressive Conservative government's drug patent legislation made substantial contributions to the Progressive Conservative Party. Figures released by Elections Canada show that in 1992, the PC Party received contributions from the Pharmaceutical Manufacturers Association of Canada and from many of the individual multi-national drug companies. However, in keeping with the corporate custom of hedging bets by supporting both of the main pro-business parties, many of the drug manufacturers also made smaller contributions to the Liberal Party

21 July 1993

Pay equity deal

The Ontario Hospital Association has agreed to give about 40,000 nurses a one-time payment of $4,100 in a pay equity deal. The payment will raise the maximum annual salary of full-time nurses from $52,000 to $54,210 by January 1996. The hospital association represents 171 hospitals. Another 53 hospitals in Ontario are not covered by the deal. Hospital association president Dennis Timbrell said the agreement will cost hospitals about $123 million in retroactive pay and an additional $66 million in annual costs by 1996. Pay equity adjustments, which compensate for past pay inequities, are not affected by the province's "social contract" legislation.

22 July 1993

AZT court case

A U.S. federal judge has ruled that the U.S. pharmaceutical company Burroughs-Wellcome is the sole inventor of the anti-AIDS drug AZT. Burroughs-Wellcome sued Novopharm Ltd. of Toronto, Barr Laboratories of Pomona, New York, and the U.S. National Institute of Health, after the two companies applied for permission to produce a generic version of AZT. Novopharm and Barr argued that the AZT patent was invalid because the drug was developed by public money, and that two scientists at the U.S. National Institute of Health were co-inventors of the drug. In a case which observers characterized as "bizarre", Judge Malcolm Howard allowed Burroughs-Wellcome to present its case and then ended the case and handed down his ruling without allowing the other side to present its case. Novopharm and Barr are asking that a mistrial be declared, but in the meantime are prevented from marketing the drug.

23 July 1993

Charities lose under "social contract"

Ontario charities in the health care field are having to turn money over to the province under the NDP government's "social contract" law. The charities are being made to turn over 5 per cent of their payroll costs for the next three years. Charities fall under the "social contract" if they receive any of their funding from the provincial government. The clawback applies even if agencies' payrolls exceed the total amount they receive from the government in the first place.

28 July 1993

Restrictions on out-of-province MDs

The Ontario government has put a moratorium on the right of new doctors coming into the province to bill OHIP. Effective immediately, doctors entering Ontario with degrees from medical schools outside the province will be able to practice medicine only if they go on salary or accept some other form of alternative payment. They will not be allowed to bill OHIP under the fee-for-service system. The moratorium is to last until March 31, 1996, when the government's "social contract" program expires.

However, the moratorium may be challenged under Canada's Charter or Rights and Freedoms. Constitutional lawyers said that the government's new rules appear to violate Section 6 of the Charter, which states every citizen has the right to pursue a livelihood in any province.

6 August 1993

Private sector bureaucracy

A new study has found that 24.8 per cent of all U.S. hospital costs go for administrative expenses, about twice the proportion spent in Canada. The study, based on federally-mandated cost reports from each of the nation's 6,400 hospitals in 1990 and published in the New England Journal of Medicine in August, estimates the U.S. could save $50 billion a year on hospital administration costs by shifting to a Canadian-style health system. A second study, by Steffie Woolhandler of Harvard Medical School and Sidney Wolfe of Public Citizen's Health Research Group, estimated that under a single-payer system, the U.S.'s total health system (not just hospitals) could save about $117 billion a year on administrative costs, including the $50 billion on hospitals.

15 August 1993

BC NDP limits payments

British Columbia's NDP government has introduced new guidelines as part of an agreement with the province's doctors under which the provincial health care plan will no longer pay for services that are not considered medically necessary. If a patient wants a service which is not considered medically necessary, he or she will have to pay for it. Prime examples of such services would be tests for which there is no medical indication. The guidelines to be applied are to be developed by the province's new Medical Services Commission, a tripartite body including government, physician and public representation. David Naylor of Ontario's Institute for Clinical Evaluative Sciences, said that the guidelines represented a step forward because "in the past, we have concentrated on the service itself, and whether it should be funded. Now we are seeing an attempt to define when and where a service is useful and to stop paying for it if it is used inappropriately." However, he added, there is also a danger that physicians will be tempted to subscribe more and more of their services to private billings once these are allowed. "They may define what is medically necessary in ways that compromise the patient's interest. Is this

also a step on the slippery slope towards privatization of our medical-care system?"

25 August 1993

Private sector growing

A steadily increasing share of Canada's health care system is being financed by the private sector, according to a report prepared by the Canadian Medical Association. "A process of privatization is going on," said Dr. Hugh Scully, chairman of the committee that presented the report to the CMA's annual meeting. The CMA study stated that the private share of total spending on health care amounted to nearly 28 per cent in 1991, up significantly from 25.3 per cent in 1985. The growth in private spending is largely attributed to increasing use of private insurance for services not covered by medicare, the lack of fiscal controls on private charges, and a rapid growth in drug costs. The report points out that more money is now spent each year in Canada on drugs than on physicians. Drug costs, including prescriptions, hospital-dispensed drugs, and over-the-counter drugs, amounted to $11.2 billion, or 16.8 per cent of all health care spending, while physicians amounted to 15.2 per cent. Drug plans, eye plans, and the cost of nursing homes are some examples of where private health care dollars are being spent.

26 August 1993

User fees slammed

User fees are an obstacle to meaningful reform of Canada's health care system — and they don't work, according to a report prepared by health economists Greg Stoddart and Robert Evans. Neither of the main reasons for user fees — deterring patient abuse of the system or reducing the cost of medicare — stand up to scrutiny, according to Stoddart. "Costs will increasingly fall on those who need and use care," he said. The report estimates that less than one per cent of total health care spending is due to patients seeking unnecessary services. Meanwhile, estimates of inappropriate use of the system generated by physicians range as high as 30 to 40 per cent, according to the report. "That is a much larger problem, and one which user charges will not address." There is no evidence that user fees deter patient abusers of the system, according to Stoddart, but there is clear evidence that they deter low-income individuals from seeking necessary medical care. Stoddart also said that it is wrong to expect patients "to diagnose themselves" before deciding whether they need to see a doctor. "How are they going to know in advance what medical services are necessary? Trying to do that may do them harm." Introducing user fees would mean that "the healthy rich stand to gain the most and the sick poor stand to lose the most."

10 September 1993

Drugs trimmed from ODBP

The Ontario government has removed 134 drugs from the list of those provided to seniors and welfare recipients. The changes are expected to save $40 million a year from the $1.2 billion cost of the Plan. Among the drugs removed from the list are calcium supplements, antacids, and digestive enzyme supplements. 36 other drugs were added to the Plan.

13 September 1993

Membership renewal

October 1 marks the beginning of the Medical Reform Group's fiscal and membership year, so it is now time to renew your membership. Renewal notices were mailed together with this newsletter. Memberships fees are unchanged from last year. They are: $195 for practising Ontario physicians, $50 for residents, interns, retired physicians, out-of-province physicians, and organizations, and $25 for students and associate (members other than physicians or medical students). Subscriptions to the newsletter, *Medical Reform*, can be purchased for $25 per year (all memberships include a subscription).

MEETINGS AND CONFERENCES

Women's health

The 1993 North American Congress on Women's Health Issues will be held in Toronto **October 7 - 9**. Contact Jeannette L. Sasmor, P.O. Box 1630, Sedona Arizona 86336 U.S.A., (602) 284-9897.

Palliative Care

Caritas Health Group is holding its fifth annual Palliative Care Conference **October 8 - 9** in Edmonton. Contact Lynda Bykewich at Edmonton General Hospital, 403-482-8086, fax 403-482-8465.

Contaminated blood products

The Canadian Institute is holding a conference on Contaminated Blood Supplies: The Notification Dilemma, on Tuesday **October 19** in Toronto. Contact The Canadian Institute, 1329 Bay Street, 3rd floor, Toronto M5R 2C4, 416-927-0718.

Redressing the imbalance

The Northern Health Human Resources Research Unit at Lakehead University is organizing 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 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.

MRG Steering Committee

The Medical Reform Group Steering Committee meets at 8 pm on Thursday **October 21** in Hamilton. MRG members are invited to attend Steering Committee meetings to observe, take part, or raise issues the MRG should be addressing. The Steering Committee meets monthly; meetings alternate between Toronto and Hamilton. For details on time and place of meetings, call 416-588-9167.

Health care labour issues

The Canadian Institute is holding a conference on Health Care Labour Issues: Coping With Raised Standards, reduced Funding, and the Social Contract. Contact The Canadian Institute, 1329 Bay Street, 3rd floor, Toronto M5R 2C4, 416-927-0718.

MRG Fall Meeting

The Medical Reform Group's fall general meeting will be held on Thursday November 4 at 6:45 pm at the Davenport-Perth Community Health Centre in Toronto. The featured speaker will be David Naylor of The Institute for Clinical Evaluative Sciences. For more information contact Medical Reform Group. Box 158,Station D, Toronto M6P 3J8, 416-588-9167.

Expanding the Healing Circle

The Canadian Research Institute for the Advancement of Women (CRIAW) is holding its 17th annual conference in St. John's **November 12 - 14**. The theme is "Expanding the Healing Circle". Contact 709-753-7270.

Vision for Reform

The College of Family Physicians and the Medical Reform Group are co-sponsoring a morning session at the College's annual meeting in Toronto on Saturday **November 20**. The subject of the session is "Vision for Reform in Ontario." More details about time, place, and speakers will be mailed shortly.

MRG Steering Committee

The Medical Reform Group Steering Committee meets at 8 pm on Thursday **December 2** in Toronto. MRG members are invited to attend Steering Committee meetings to observe, take part, or raise issues the MRG should be addressing. For details on time and place, call 416-588-9167.

Helping the bereaved male

The twelfth King's College conference on Death and Bereavement will take place **May 16 - 18, 1994** in London Ontario. The topic is "Helping the Bereaved Male". Contact King's College Centre for Education about Death and Bereavement, 266 Epworth Avenue, London Ontario N6A 2M3, fax: 519-433-0353.

PUBLICATIONS

Health promotion strategies

Summarizing almost 100 health promotion programs in health centre across Ontario, the Association of Ontario Health Centres' Health Promotion Committee has published a revised edition of *Health Promotion Strategies in Community Health Centres and Health Service Organizations in Ontario*. The book provides information on why each program was started, its goals, target group, activities and a brief assessment of what worked and what didn't. It also includes contact names, addresses and telephone numbers for each program. $15 from Association of Ontario Health Centre, 5233 Dundas Street West, #401, Islington, Ontario M9B 1A6, 416-236-2539, fax 416-236-0431.

Social marketing

The Ontario Ministry of Health has published a booklet, *Social Marketing: A Communications Guide*, which seeks to acquaint public health professionals who lack formal training in communications or marketing with the elements of social marketing. The booklet takes a hands-on approach to teaching individuals and organizations how to build communications activities to support their community health promotion projects. $15 from Health Information Centre, Communications and Information Branch, Ontario Ministry of Health, 9th floor, Hepburn Block, Toronto, Ontario M7A 1S2, 416-327-4327, 1-800-268-1153.

Social marketing

In his paper *Promoting Better Health in Canada and the U.S.A.: A Political Perspective*, Roy Cunningham describes how health promotion policies have developed in the two countries and examines the roles played by government, public health associations, advocacy groups and the media. Contact Roy Cunningham, Department of Health, Eileen House, Room 624, 82-94 Newington Causeway, London SE1 6EF, United Kingdom, fax 011-44-71-972-2892.

Getting the Word Out

Getting the Word Out: A Practical Guide to AIDS Materials Development, is intended for those who have to prepare AIDS materials for different constituencies, and is written by American community health educators who have produced these kinds of resources. A key concern of the book is creating "culturally sensitive" materials appropriate to the community for which it is intended. The advice given could apply to preparing materials on many other issues as well as AIDS.

Available for $19.95 from Network Publications, P.O. Box 1830, Santa Cruz, CA 95061 U.S.A., 1-800-321-4407.

Women's Directory

The Latin American and Caribbean Women's Health Network has published the *Women's Data Base Directory*. Published by Isis International, Santiago Chile.

Patenting life

The June issue of the *Economic Justice Report*, published by the Ecumenical Coalition for Economic Justice, is a special issue on the theme "Free Trade and Patenting Life: Is Nothing Sacred?" The *Report* looks at the substantial sections of the North American Free Trade Agreement (NAFTA) which in fact "have very little to do with trade but instead covers intellectual property rights." The areas affected include pharmaceuticals, funding and direction of scientific research, and moves to patent life forms, including bacteria, plants, animals (Dupont has patented a mouse), and genetic codes mapped by researchers. Available from Ecumenical Coalition for Economic Justice, 11 Madison Avenue, Toronto, Ontario M5R 2S2.

Export opportunities

The Health Service Exports Advisory Committee of the Ontario Ministry of Health has released a report entitled "Outward Bound: Strategies for Maximizing Export Opportunities in the Ontario Health Industry". The report, released September 9, advocates that private companies, associations, institutions, and government get together to form a for-profit corporation which would bid on major international health consulting contracts. "These contracts could also lead to increased export of Ontario health products." "This kind of private and public partnership will drive economic renewal in Ontario," said Health Minister Ruth Grier.

Towards Justice in Health

The summer 1993 issue of *Towards Justice in Health* (Volume 2, Number 1) has articles on NAFTA and Health, RNA Layoffs, Infant Formula Marketing, and Racism in Nursing. Available from Nurses for Social Responsibility, P.O. Box 46040, College Park Post Office, 444 Yonge Street, Toronto, Ontario M5B 2L8.

Health care facts

The July 1993 issue of *The Facts*, published by the Canadian Union of Public Employees (CUPE) is a special issue on health care. Articles include "Betraying a sacred trust: The gradual starving of medicare", "User fees" Kim Campbell's Medicare", "Twin Shadows over Medicare: Deterioration and Americanization", and "The Quebec Experience". Available from Canadian Union of Public Employees, 21 Florence Street, Ottawa, Ontario K2P 0W6.

Science sells out to low bid

By Maude Barlow and David Noble

The Columbian scientist who recently developed the first vaccine against malaria then gave it free to the world has set a shining example of scientific integrity that puts his Canadian counterparts to shame.

Spurning multimillion-dollar offers from multinational pharmaceutical companies, which sought to gain monopoly control over the vaccine through patents and licenses, Dr. Manuel Elkin Patarroya, "on behalf of the Colombian people," transferred all legal rights to the vaccine to the World Health Organization, thereby ensuring that it will remain cheap and accessible.

In Canada, meanwhile, the nation's bio-medical research establishment has unabashedly sold itself out to those same pharmaceutical companies, actively working alongside them to extend their monopoly control over medicines at the expense of the Canadian people.

Last October, a new political lobbying group, the Coalition for Biomedical and Health Research, was founded in Ottawa to increase funding for biomedical and health research.

Founding members of the coalition included the Association of Canadian Medical Colleges, representing the nation's 16 faculties of medicine, the Canadian Federation of Biological Societies, representing 17 scientific organizations and the country's 6,000 biological and biomedical scientists, and the Health Research Foundation of the Pharmaceutical Manufacturers Association of Canada, representing the major pharmaceutical companies.

The formation of the coalition was timely, for at that very moment debate was raging over the now infamous Bill C-91, which gave extended patent protection to pharmaceutical companies. It is estimated that this new law, which is certain to cripple the domestic generic industry, will eventually cost Canadians $4 billion in higher drug prices, jeopardizing the future of both employer and provincial drug benefit programs and medicare itself.

The coalition's maiden effort was to mobilize support for Bill C-91, providing seemingly disinterested expert testimony and legwork on behalf of the legislation. The coalition's first formal position was to "recommend that Bill C-91, the Patent Act Amendment Act, 1992, be passed by the federal parliament immediately," to "increase intellectual property protection for patented pharmaceuticals in Canada to minimal international standards."

The rationale for these scientists' support of multinational monopoly interests is their expectation of industry support for their research projects.

Coalition chairman D. Howard Dickson, associate dean for medical research at Dalhousie University, in a lengthy and friendly September 28 letter, thanked Nova Scotia MP Ronald MacDonald, the Liberal critic on consumer and corporate affairs, for his public criticism of Bill C-91.

Such pressure, he said, was "indeed having a very positive effect" in making the industry more responsive to the scientific community's interest in greater corporate investment in their research activities. He described how such parliamentary posturing had already helped his own faculty's effort to negotiate a modest ($1.5 million per year for five years) research grant from Merck Frosst. "I realize that in relative terms, this represents a small amount if it can in fact buy our support for Bill C-91," Dickson acknowledged, but he expressed his "hope" that this scientific sellout would prove more fruitful for biomedical research in the long run.

These scientists' lobbying efforts betray their arrogantly self-serving assumption that what is good for them must invariably be good for society as a whole. But are the interests of these scientists really consistent with the larger public interest? No doubt the modest industry investment in biomedical research will further the careers and personal ambitions of the scientists but will it compensate the rest of us for the loss of cheaper generic drugs and the erosion of our drug benefit plans and medicare? Hardly.

Will it even give Canadians a fair return on the research itself? Again, no. All industry research investment comes with strings attached, in the form of proprietary control over the research results, although the taxpayer continues to pay the lion's share of research costs. "Anyone even moderately familiar with academic science in Canada knows the rarity of industry funds," concedes the coalition's executive director, Clement Gauthier.

Thus industry investment in academic research actually turns out to be more of a subsidy to industry than the other way around, a privatization of the benefits, through patent and licensing arrangements, but not the costs. Thus, the public continues to underwrite the bulk of the research yet forfeits control over the results. And, especially now after Bill C-91, we end up paying monopoly prices for whatever is produced.

Sellout science serves these scientists and, of course, their corporate sponsors (and political partners) but not the rest of us. It is part of a worldwide trend, as evidenced in the Intellectual Property Rights provisions of the North American Free Trade Agreement to view knowledge as private property instead of mankind's common heritage, and to concentrate the production and ownership of technology and science in transnational corporate hands.

It's high time such Canadian scientists were taught some social responsibility, like that so admirably demonstrated by their courageous colleague from Columbia. But we can't afford to wait for that. With the patent legislation in place and the corporate penetration of university research proceeding apace, it would be foolhardy to rely upon any such belated enlightenment to safeguard the public interest. Rather, closer public scrutiny of scientific research activities must become the order of the day, which presupposes full public disclosure of all proprietary deals (and relationships) between public institutions (and publicly supported researchers) and private firms.

At the very least, all arrangements with multinational companies must contain domestic content provisions that guarantee some return to the Canadian taxpayer in jobs and revenues generated by research, development and manufacture. Some Canadian scientists have decided to sell themselves out for the money. Only the most careful public vigilance will ensure that they don't sell the rest of us out in the process.▼

Maude Barlow is chairperson of the Council of Canadians. David Noble, co-founder of Forum for Higher Education in the Public Interest, is a professor at York University. This article first appeared in the Toronto Star, June 29, 1993.

Timely house call for health system

By Michael Rachlis

The recent decision by the Ontario Medical Association to negotiate a reduction in the premiums paid for house calls has sparked a major argument in the medical community.

Are free-standing house-call services a frill or a necessary component of modern health care? Is Ontario/s health care system threatened by spending $10 million to send radio-controlled doctors to see people with trivial complaints? If it is, why isn't it moribund from the bill of $200 million a year to see people with colds?

The answers to these questions are revealing and they uncover an opportunity for the Ontario government.

The OMA has not suggested eliminating house calls. Rather, it has recommended discounting the OHIP house-call bonus for those physicians for whom house calls are more than 20 per cent of their billings.

The OMA says that most doctors who derive more than 20 per cent of their earnings from house calls have no regular office and, hence, no regular office expenses. Furthermore, the OMA asserts that many of these house calls are unnecessary.

On the other hand, Dr. Tom Burko of the Medvisit Housecall service says they are "doing a job that nobody else wants to do."

Who is right?

In fact, there is considerable truth in both positions. The vast majority of house calls made by house-call services are, strictly speaking, unnecessary. Most are for colds and flus that could easily be dealt with on the telephone or by the family doctor the next day.

On the other hand, the proprietors of house-call services are also right that most family doctors don't talk on the pone and aren't available after hours. Many can't see patients the day they are sick.

That, however, doesn't mean regular family doctors focus their practices on those who really need to see them. Last year, OHIP paid doctors with regular practices $200 million to see people with colds. All this while people with AIDS can't find doctors to treat them.

One-third of Ontario's family doctors answer their phone after regular hours by referring patients to emergency departments, walk-in clinics, or house-call services. Especially in the Greater Toronto Area, family doctors have moved to regular business hours with house-call services providing their on-call.

There are no requirements from OHIP for any particular after-hours coverage. There are no standards set by OHIP, the OMA, or anyone else for family doctors to see patients who get ill. They can all be sent to emergency departments or house-call services.

Of course, this is consistent with Ontario's laissez-faire approach to physicians. We don't have socialized medicare but rather public payment for private fee-for-service practice.

As a consequence, better family doctors practicing better medicine take home less money than their colleagues who have installed revolving doors in their waiting rooms. Or the ones who have abandoned their offices for their cars.

A doctor who sees 60 patients a day with trivial problems can take home four times the income as one who focuses on 20 who really need medical care. And the high rollers can run up bills for labs, drugs, and specialists that are twice that of the prudent practitioner.

Since 1974, several Ontario reports have recommended basing primary care services on health promotion and disease prevention, delivering them with multidisciplinary teams paying for them with non-fee-for-service reimbursement and providing house calls and other services according to need.

However, through three governments, Ontario's response has been inadequately resourced and poorly co-ordinated.

True, there are now 46 community health centres but Quebec has 170. Furthermore, Quebec has given them key, clear roles in their health care system.

Ontario also has 90 health service organizations (HSOs) which are funded by per capita, non-fee-for-service payments. But the HSO program has been starved of resources since its inception.

The government should gratefully accept the OMA's position to discount fees for house-call services but remind the profession that, collectively, Ontario's surplus of family doctors is not meeting the public's needs.

The ministry should proceed, as planned, with an educational program to teach the public how to manage their own minor illnesses. The program should be developed in co-operation with the OMA and other relevant health organizations. Then the ministry should fund a program to service people with questions about their health.

In Quebec, the public knows they can always speak to a nurse at their local community health centre. In Ontario, with an incomplete network of health centres, calls could be routed to public health units or hospitals. How about 1-800-4A-NURSE?

Then the ministry of health should request that Ontario family doctors agree to have minimum office hours and provide on-call service. These tasks could be shared with other family doctors but not free-standing services.

The issue of house-call services is more complex than whether consumers should be able to order up doctors like pizzas. The proliferation of house-call services reveals much that is wrong with medicare.

The government should seize upon the OMA offer as a special opportunity to make headway on the public's agenda for quality, efficient primary care.▼

Michael Rachlis is a Toronto physician and health policy consultant. He is a member of the Medical Reform Group. This article orginally appeared in The Medical Post.