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

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General meeting to hear about use and abuse of practice guidelines

Practice guidelines will be the topic of discussion at the Medical Reform Group's fall general meeting on Thursday November 4.

Later in the evening, there will also be a showing of a short film, *Doctor to Doctor*, by U.S. filmmaker Robert Purdy. A number of MRG members participated in the making of the film, which compares health care in the U.S. and Canada.

Speaking on practice guidelines will be David Naylor, head of the Institute for Clinical Evaluative Studies.

Practice guidelines are favoured by those who want to see a health care system that provides effective health care to all without barriers, but are also seem as a useful tool by those who want to restrict medicare services and create a momentum for increasing privatization in the health care field.

David Naylor is one of the foremost experts on practice guidelines.

The meeting will begin at precisely 6:50 p.m. sharp. Dinner will also be available at the meeting, starting at 6 p.m. Registration is $10 with dinner, $5 without dinner.

The meeting will be at the Davenport-Perth Community Health Centre, 1900 Davenport Road, Toronto.▼

INSIDE

Drug reform mistakes

By Mimi Divinsky

One can no longer keep silent about the serious mistakes continuing to be made by Ontario's Drug Quality and Therapeutics Committee in its attempt to make substantial changes to the Ontario Drug Benefit Plan.

Many of the evaluation criteria it adopted have had our long-standing support — reducing costs without changing benefits or risk and encouraging physicians to amend ill-considered prescribing practices.

Yet as a GP in downtown Toronto I have had a chance to see some of the adverse consequences of changes introduced in August 1992.

Now (September 1993) a new Ministry of Health Fact Sheet notifies us of further deletions — calcium tablets, antacids, and digestive enzyme supplements will be added to antihistamines and vitamins, deleted last summer.

The fact sheet informs us that patients with cystic fibrosis will be able to obtain enzyme supplements through ten designated hospital pharmacies in the provinces. But what about those patients with proven need, caused by other diagnoses?

The fact sheet also informs us that there are alternative "covered" medications for the treatment of allergic reactions, neurodermatitis, gastritis, and osteoporosis. Yet all these alternatives are more expensive, 'second-line' drugs known to be effective, but at the 'price' of increased side effect risks.

The primary issue is not whether the deleted products are valid therapeutic agents — there is no contradiction here.

But the Ministry believes that the burden of cost should fall to the patient — "Products removed as benefits are available without prescription at retail drugstores and most are relatively inexpensive."

But "inexpensive" is of course relative to income: Here then is one contradiction — that a physician must choose between alginiciacid (Gaviscon) and ranitidine (Zantac), between dimenhydrinate (Gravol) and prochloroperazine (Stemetil). The latter are four to five times as expensive and have significantly more potential side-effects, but are "covered" by ODP for other reasons.

The other contradiction is that between NDP policy and practice — what has happened to its condemnation of user fees and its commitment to universality?▼

Saving low-volume emergency departments

The following letter was sent to Dr. T. Dickson, President of the Ontario Medical Association, by Dr. R. D. Fletcher, President of the Society of Rural Physicians, an organization formed last July.

Ontario rural communities are waiting for the OMA to make the right decision, but it must act soon, before more emergency departments are forced to close.

The increasing age and accelerating burnout of rural physicians providing emergency services was forecast in 1986. This led to the formation of a Section of Rural Physicians within the OMA. To date, working within the OMA has not moved the rural doctors any closer to a solution to this urgent problem.

What is the problem?

Simply stated, the problem is that working conditions for rural doctors are archaic. There is no place in this day and age for physicians to have to work 24 to 48 hours and even 72 hours in emergency departments, and still be expected to

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Saving low-volume emergency
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run their offices the next day. There are insufficient visit volumes in small hospital emergency departments to attract physicians from outside the community to do this type of work. Neither is there enough volume to remunerate the physicians such that they could close their offices and take a sleep day after an emergency department shift.

Small rural hospitals play a vital front line role in providing emergency care for the bulk of Ontario's geographically dispersed population. The physicians who perform emergency duty continue to do long and frequent shifts, despite inordinate fatigue, sleep deprivation, large office workloads and a high incidence of family disruption and dysfunction.

Many individuals and groups of doctors living this life are being consumed by it. They need a way to address the workaholic lifestyle that is forced upon them by where they live. Without a solution, the end result will be haphazard and widespread closure of emergency departments around the province.

The result of closure will be the collapse of the primary and secondary industries that sustain the social and economic well-being of rural communities.

This crisis is well understood by the Ontario Hospital Association and the Ministry of Health. The elected representatives of the affected districts have been entirely supportive. However, the OMA has so far not responded to the cry for help from rural physicians and their communities. Recently, the mandate to deal with this issue has been transferred to the OMA in the social contract discussions. The agreement would allow alternate forms of reimbursement to be developed for rural emergency departments.

What would it cost to solve the problem?

The OMA would have to initially transfer a total of $15 million from its global budget to designated rural communities. The process of designation of these needy communities and the transfer of rural equity to create viable hospital emergency department staffing is an urgent priority in rural-northern Ontario.

Do you realize this is your problem to solve? Do you care enough about your rural colleagues and their communities to address this inequity?

Rural Ontario is urgently awaiting your response.▼

R. D. Fletcher, M.D.
President
Society of Rural Physicians

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.

Did doctors get a sweet deal from the social contract?

By Rosana Pellizzari and Gord Guyatt

There has been a lot written about Ontario's Social Contract. The intent seemed honourable: in the light of a shrinking economy, maximize cost-savings and minimize job losses.

To be just, the contract should have taken more from those who could afford to lose the most, i.e. the high income earners.

The process was gruelling and the results questionable. In the early days of negotiation, the Government raised the spectre of unemployed young doctors. The Ontario Medical Association (OMA) worked hard to fan the flames of public opinion, taxing each of its members an additional $200 to pay for the effective ad campaign warning that Bob Rae's government could be hazardous to our collective health. It worked.

Health care workers have been a major target of the Social Contract. As the nature of the agreements becomes clear, it is evident that the highest-paid health workers, physicians, have largely been spared.

Although all physicians billing OHIP will have 4.8% of their earnings "held back" as of October 1993, this will be adjusted later when it is determined whether the "hard cap" of $3.9 billion has been met. This hard cap represents a 2.49% decrease in overall physician billings from the 1992-93 fiscal year. The cap for the subsequent two fiscal years is approximately $3.86 billion, a reduction of 3.62% in comparison to 1993-94.

There are problems with "hard caps" since they penalize all physicians equally, including the ones who don't have high volumes and those who reduce their own utilization by working fewer hours.

However, the OMA has both the physicians' membership dues, i.e. fiscal resources, and the Government's blessing to solve that set of problems.

A letter from the President of the OMA, dated September 27, 1993, explains the "hold back" to physicians and gives suggestions for ways of lowering total OHIP billings, such as being more judicious about referrals to specialists and the number of lab tests that are ordered.

Perhaps physicians will finally stop wasting resources on unnecessary lab tests — and we will learn once again that monetary disincentives prove to be more effective at changing behaviour than years of clinical guidelines and expert opinion.

These reductions are less than those imposed on other, much less well-paid health care workers. However, there is a bigger problem. A number of provisions of the agreement will mean physicians are unlikely to take any reduction in income at all.

In return for hard caps, physicians received several peace offerings.

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Not all doctors got off lightly

By Bob James

I have some concerns about Gord Guyatt's article, "Doctors get off lightly, MRG says", in the October issue of *Medical Reform*. I have concerns about the generalisation implicit in the headline and in the statements within the article.

While I agree that fee-for-service physicians have gotten off lightly (and particularly the higher-paid ones: the reduction in OHIP fees is across the board, even though the over-charging is mostly by the high-rollers), I have trouble with saying that this is true of all physicians.

I can speak most clearly for the HSO part of the equation. Under the terms of the Social Contract which we signed (We had no choice but to sign it: where is the right of free collective bargaining?), we had a rollback of 5.2% on our capitation rates. This is higher than for the rest of the profession.

We also have lost ACIP (the Ambulatory Care Incentive Program), which had provided us with some moneys to begin to look at alternatives to strictly curative medicine (These moneys had been derived from the statistical "savings" we were able to have for our patient population relative to the rest of the region's population.) ACIP has been replaced with a charge-back equal to 50% of all primary care costs incurred by our patients outside our practices. Note that an *incentive* has been replaced by a *deterrent*.

The overall cost to my practice has been a reduction of over 30% in my income on a year-to-year basis. While no one is going to cry over my income or the incomes of doctors in general, this is a quite noticeable decrease.

The government has said it will negotiate with us a new structure for working within the HSO program. They, however, took over six months to appoint their negotiators to the committee. The doctors who work on my side of the issue suggested to the government that it would be a good idea to provide an incentive for preventive work, or that it should help with the costs of extra services to keep people in the community. The government responded to this by saying that this is what any good GP would do.

Whenever there has been a suggestion that the government might help with the provision of primary care, they have refused and stonewalled.

And they are not dealing with OMA die-hard right-wingers. The people on the HSO side of the table are responsible physicians who are trying to maintain an experimental program against what appear to be great odds.

Many people would argue, with reason, that the HSO model has not proven itself to be much better than the fee-for-service model, in terms of outcomes. That may be correct, or it may mean only that the right studies have not yet been done. A similar argument could be made against the CHOs, CHCs, hospitals, etc. So where does that leave us?

I understand that the physicians generally have job security and satisfaction well above the average worker. However, at this point, I do not feel either secure or satisfied in my job. I feel the Social Contract has, unfortunately, given the government an opportunity to engage in profession-bashing (including doctor-bashing). I would not like to think that the MRG is doing the same thing.▼

Sweet deal?

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Currently, some services paid for by OHIP are not medically indicated or always effective. Rather than an overall review of the fee-for-service schedule, the OMA and Government will proceed with "de-listing" services. De-listing services opens the door for private insurance companies to move in and offer coverage, something which may lead to two-tiered medicine: one set of services for the poor, and another set for the privately insured. This represents an erosion of our universal health care system.

Privately insured patients may be able to pay their way to the operating table, leaving less time available for the "un-insured", making waiting times for elective procedures even longer than they already are. To quote a Chief of Surgery: "If doctors can set their own fees for these (de-listed) services, and in a sense work outside the system why would they continue to treat trauma patients? This way they make good money and don't have to get up at 2 a.m." (Dr. Girotti, *Ontario Medicine*, September 20, 1993).

A real gem for the doctors from the sectoral agreement is the ability to incorporate, and therefore take advantage of tax shelters. An article published in the September issue of *Physician's Management Manuals* declares "$20,000 More in Your Pocket". Not bad for a contract which was supposed to decrease expenditures, not tax revenues.

In addition, the Government agreed to amend the Health Insurance Act through Bill 50 to allow third party payment for uninsured services, and to allow physicians to bill the patient directly. The patient will then be entitled to recover the money from the third party requesting the service. Uninsured services include notes for absenteeism, camp or school physicals, driver's examinations, completion of welfare forms, transfer of records etc.

Since extra-billing was defeated almost a decade ago, many physicians have been charging patients for services such as these. With Bill 50 in place, physicians will be able to protect incomes by offloading charges onto individuals and others.

But perhaps the most serious outcome of the OMA deal will be further delay of an already very slow reform in health care which was promised by the Ministry of Health in a much-publicized media event in January 1992. Doctors are important stakeholders and should be included in discussions concerning healing and illness. But doctors can take control of the discussion, potentially dominating and preventing meaningful change. The agreement strengthened the OMA's role in the ongoing discussions on primary health care reform and the development of a community health framework by establishing a sub-committee of the Joint Management Committee to "advise" on "appropriate" changes.

Given the broad scope of primary and community care, consumers and other health care providers may find that, once again, they have been marginalized by the powerful M.D. lobby.

There is little doubt that these are hard times. But it does appear the government has allowed the most privileged group in the province to escape without sacrifice. Worst of all, the government has compromised universal health care and its reform agenda to strike a deal with the doctors.▼

Rosana Pellizzari and Gord Guyatt are members of the Steering Committee of the Medical Reform Group of Ontario.

NDP performance diverges from principles

By Gord Guyatt

Bob Rae's New Democratic Party, while in opposition, spoke as an advocate of the disadvantaged and the less powerful, and as a champion of innovative change.

In the area of health care, the Ontario NDP platform included an ardent commitment to maintaining universality, and a goal of fundamental restructuring of health care.

An examination of the NDP's health-care record since it has been in power shows how far its performance differs from this plan.

The first departure from prior NDP policy has to do with changes to the Ontario Drug Benefit Plan.

In demanding that seniors make partial payment for drugs covered under the ODBP, the Rae government has made a direct attack on universality. The ODBP currently pays full costs for all prescription drugs for those over 65. The policy will end in 1994 with the introduction of user fees for those who fail some yet unspecified means test.

The Chair of the drug-programs reform secretariat defended the decision by saying that the user fees "will be a deterrent to utilization. Many seniors often get more drugs than they require." This line of argument assumes that patients are responsible for, and capable of determining utilization. Are patients supposed to decide which drug prescribed by their physician is necessary, and which is not? Clearly, they cannot.

The argument that user fees are the solution to over-utilization of health care is the sort of reasoning one might have expected from Kim Campbell or Preston Manning as they flirted with destroying our universal health care system. User fees do deter utilization: of needed drugs and services as well as unneeded drugs and services, and in those who can least afford to pay. For elderly people who need medication, the NDP policies add the burden of payment to the burden of illness.

In a related change to the ODBP, the government has followed many recommendations of the Drug Quality and Therapeutics Committee whose goal has been to remove unneeded or ineffective drugs from the ODBP formulary. All to the good.

Unfortunately, the government has also chosen to remove many commonly used effective medications, including

What does federal election mean for medicare?

By Vera Tarman

If you want to save medicare, vote NDP", said Audrey McLaughlin. "User fees will challenges universality", said Chretien. Federally funded medicare "with no strings attached" was what Manning said. In the midst of the campaign a Conservative document was leaked suggesting that medicare, among other social programs, would be cut after the election...

How real was the election debate about medicare?

Certainly medicare used to be a federal issue worthy of debate. The 1967 Medical Care Act, which heralded the onset of universal medicare, and the Canada health Act of 1984, which confirmed its principles, (thereby ensuring that every Canadian could count on universal, comprehensive, publicly financed, portable health care) has made the federal government a crucial player in the provincial health care plans of the country.

We must also remember, however, that the federal government has been forfeiting this pivotal position. Since the Established Programs Financing Act of 1977, the federal government contribution to our health care has been diminishing, so much so that federal cash payments are expected to be completely eliminated in Ontario by the year 2002-2003. Within the next five years, the federal government's role in health care will become purely symbolic. Any federal debate about users fees or program cuts will be meaningless rhetoric.

Public health care is indeed in jeopardy. This year alone, medical services in Ontario, such as the annual health exam, medical examinations required by work or school, have become de-insured. Over the last few months, many drugs, from complex heart medications to simple antacids, are being removed from the provincial drug formulary. This means that patients will be forced to pay for services and drugs once covered. This contravenes the principle of comprehensive coverage.

Analysts have forecast the growth of a private health insurance market, generated to pay for the increasing number of services that medicare no longer covers. The emergence of private insurance is another principle of medicare overturned.

The future looks even bleaker. The free trade agreement has promised U.S. companies a "level playing field" so that taxes which pay for our health care could be deemed an unfair subsidy.

NAFTA, a free trade deal expanded to include Mexico, will make it even more difficult to maintain medicare as we know it. All levels of government, from federal to provincial to local governments (even hospital boards) will be forced to adhere to the principle of non-preferential treatment. That means that small government funded nonprofit agencies will be forced to compete with interested multinationals. Those health and social services which are currently exempt from NAFTA will be reviewed and may be covered by 1998.

NAFTA will also intensify market pressure already evident in health care. The expansion of business in health care will continue to pervade: nursing homes and home care, hospital management services, contracting out of hospital services (dietary, nursing, laundry), diagnostic related groups (treatment related plan based on diagnosis) are examples of privatization already in process.

Medicare is being undermined. The previous Progressive Conservative government deliberately set out to remove the federal government's ability to protect Canadians, by implementing free trade and slashing transfer payments. Promising to save medicare without seriously addressing the driving forces that are changing medicare — declining transfer payments, FTA, NAFTA, privatization — is irresponsible, and misleading.▼

antihistamines, antacids, and calcium supplements. For these medications, even the poorest sick elderly person must now pay out of pocket.

Physicians can try to help their elderly patients who need drugs which are not on the revised formulary by requesting special authorization from the Ministry. One of us recently made this request for use of hydroxyzine, a drug that can relieve itching in patients with skin rashes. The Ministry refused the authorization, stating that the purpose of the ODBP is to provide essential medications. Is the Ministry suggesting that the poor elderly who cannot pay for medication designed to relieve symptoms should just suffer? Apparently so.

Ironically, the physician who was refused the authorization could have moved on to give a more expensive drug that is still covered by the ODBP. The Ministry's attempt to save money may thus be not only unfair, but ineffective.

A second important departure from their prior principles is the NDP strategy for how workers in the health sector bear the burden of cutting the deficit. Behaviour consistent with prior policy would have the NDP implement cuts so that those who have the most will give up the most. Yet the highest paid health workers, physicians, will suffer less drastic cuts than much lower-paid hospital workers.

The NDP government has made a deal with the Ontario Medical Association that makes a small reduction in the overall cap on physicians' billing. If the cap is exceeded conscientious physicians who take time with their patients and therefore earn less will be penalized just as heavily as the high-billing physicians.

There is another catch. Part of the deal was the de-listing of services that OHIP currently covers. That means that for a number of services patients will now have to pay out of their own pockets. Physicians collect these billings, which don't count toward the cap. This means that doctors will get around the billing cap, and their incomes will actually increase. The government has allowed the highest-earning group to avoid the pain of the social contract, and in the process further jeopardized universal health care.

In a third inappropriate response to its budget dilemma, the NDP has denied health-care coverage to foreign nationals living in Canada. Though this is the right strategy for executives of multi-national companies, or students who can pay for an education away from home, the Rae government has also targeted refugee claimants, who may wait up to a year for a decision on their case, and live-in domestic care workers. No one is more vulnerable to the financial burden of ill health than these low-paid and unemployed people. They do not, however, have an effective public voice, and are essentially unable to defend themselves. Once again, this last criterion seems to be the basis of the government's strategy.

The government has created a sense of dire urgency about the deficit, and this sense of urgency has allowed them to take extraordinary measures. They have slashed payments to hospitals and health workers and, as we have pointed out, have targeted the most vulnerable for these cuts. What they have not done is to use their crisis to make desperately needed, but politically difficult changes in the health care system.

There are changes in the structure of the health care system that could improve efficiency, and thus decrease costs, while maintaining quality of care.

Chief among these is altering the method of physician reimbursement. In the current fee-for-service system, the physician is reimbursed every time she or he sees a patient or performs or interprets a test. The incentive is to see patients more often, and order more tests. In a fee-for-service system, there is no effective method of controlling health care utilization or undertaking systematic planning. In fact, conscientious physicians who take extra time with their patients are penalized.

In a capitation-based system, on the other hand, the physician is paid a set fee for each patient. The fee is adjusted for the age of the patient, and can be adjusted for other indicators of how much care the patient is likely to need. The payment is the same, however, no matter how often the physician sees the patient. In such a system, there is no financial incentive to deliver unnecessary services, and there is considerable scope for rational, advanced planning of health-care resources. Incentives to deliver optimal care (such as a bonus if a physician completes immunizations for all the children in his or her practice) can be built into the system.

Capitation has worked well in Britain when instituted across the entire primary health-care system. This is very different from the ill-conceived policy of placing small numbers of physicians on capitation. This piece-meal approach has been tried in Ontario over the last five years, and has had major problems. An integrated, system-wide strategy is required.

A capitation-based system could be complemented by a network of community health centres in which health workers, including physicians, would be on salary. Community health centres can provide comprehensive services, and Quebec has demonstrated that a network of over 100 community health centres throughout the province can work well.

Major structural reform based on alternative methods of physician reimbursement would eliminate walk-in clinics, which have proliferated in Ontario over the last five years. These clinics encourage duplication of services because patients often visit the clinic and subsequently their family physician. Care is delivered most efficiently and effectively when the physician has an understanding of the long-term health needs of the patient; this cannot happen in walk-in clinics where the patient is seeing a different doctor every visit.

There are other major structural changes the government could introduce.

Physicians currently receive minimal feedback on their drug prescribing, and patterns of practice vary widely. Much of physicians' information comes from the pharmaceutical industry. More effective quality control of drug prescribing and providing objective information to physicians to counter misleading drug advertising could remedy excessive and inefficient prescribing practices.

Many physicians currently have facilities for conducting expensive tests in their offices. These are also paid on a fee-for-service basis, providing physicians with a tremendous incentive for ordering tests on as many patients as possible.

Restricting test facilities to hospitals and independent health facilities would remove this incentive.

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

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NDP violates own principles

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Currently, pharmaceutical products are not licensed until the company has demonstrated that the product does more good than harm. Similar licensing procedures for diagnostic and surgical health technologies should be instituted. The criterion for funding would be the demonstration of patient benefit. There are a wide variety of expensive procedures physicians undertake that are expensive and of unknown effectiveness.

The changes we are suggesting would all be resisted by powerful constituencies. Rather than standing up to these constituencies, the government has chosen to victimize the most vulnerable. The government's strategy focuses on cost-cutting, targets hospitals and public-sector unions, and rejects major changes that would improve efficiency while maintaining quality of care. It is a sad and disappointing choice.▼

MRG Steering Committee members and other members of the MRG contributed to the writing of this article and to the discussions which formulated the ideas it contains.

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.

Different vision of health care

We received our membership renewals two weeks ago. They have been sitting on the counter and have prompted much discussion between Janet and I. We have decided that we will not renew our memberships. We feel that the MRG deserves an explanation for our actions.

Although we still agree with the three general principles on which the MRG is based, we feel that the vision of health care proposed by the MRG does not reflect the realities of health care in the North. Further, our recent exposure to a local CHC and other non-fee-for-service organizations has caused us to re-evaluate OUR views on appropriate funding schemes.

As far as the CHC goes, we have a brand new 2.5 million dollar building with 10 full time staff including two administrators, a nurse practitioner who doesn't see patients, a social worker who doesn't do counselling, and less than 100 patients on the roster. A recent 1 1/2 hour full staff meeting was held to discuss the pros and cons of music vs. silence while telephone callers are on "hold". All this to "service" a population that until recently was cared for by an elderly GP (who was still seeing patients from his hospital bed two days before his death).

I know that it is possible to argue that the problem is due to lack of leadership and accountability within the CHC but you only need to look at other CHCs to see other examples of similar waste.

One of us recently enquired (as part of a role as voluntary member of the hospital psychiatric services committee) into the volume of counselling done by the hospital psychology department and our local sexual assault centre. In both cases the counsellors saw FOUR patients per day! The remainder of the working day is spent with paperwork and meetings.

Again, one might argue that this is an aberration and does not reflect similar salaried positions elsewhere but we challenge you to prove it. You might also argue that the quality of care is greater with the salaried staff than that provided in four hours of similar therapy by a skilled physician in a morning but we doubt that you can prove that either.

Janet looks at the evolving midwifery programme with envy. A salary of $40 - $60 thousand (and possibly benefits as well), one in four call and all this for 40 deliveries per year! Again one can argue that the quality of care will be higher than the AVERAGE primary care physician but the overall expectations and workload are very different as well.

The emphasis on HSOs is also one we are beginning to question. The examples in Hamilton and area are for the most part in affluent (and therefore healthy) areas of the region. This is only natural given the lack of profitability of capitation funding in areas with a heavy disease burden.

As far as Dr. Rachlis' suggestion of Dial 1-800-4-A-NURSE, with all respect, given our experience, nursing is more interested in creating their own bureaucracy and "policy and procedures" manuals (all of which seem to shift responsibility for decisions to physicians), than providing decisive, quality, patient care.... There are of course excellent nurses but no greater a percentage than excellent physicians. The realization that the training, skills, and responsibility taken by the two groups ARE different seems to escape many in the MRG.

Whether our views are shifting to the "right" as a result of a "circle the wagons" response to the constant criticisms of physicians as a group we do not know, but we ARE sure that the MRG (like the OMA) no longer represents our views.

We would like to say that we have the time, energy and commitment to make these views heard within the MRG but time, distance and the pressures of our lives make this impossible.

We will instead, work to change things at a local level and hope that some day an organization evolves that wants to work to reform the present system rather than replace it with a system with equal but different flaws.

We would like to close by expressing our gratitude to the MRG for its prior efforts on key issues such as extra-billing.

We are concerned however, that it (like the provincial NDP), sees the world through Toronto-coloured glasses that distort reality. Finally, we are fearful that the MRG (again like the provincial NDP) will not recognize this until many of its former supporters are disillusioned and alienated.▼

Steve Roedde, M.D., C.C.F.P.
Janet McLeod, M.D., C.C.F.P.

Steering Committee update

The Medical Reform Group Steering Committee has dealt with a wide variety of issues over the last number of months.

Primary care reform

Primary health care reform was one continuing focus of discussion. The November 4 general meeting on practice guidelines, and the November 20 session being co-sponsored by the MRG and the College of Family Physicians on "Visions for Reform", are both outcomes of these discussions.

Steering Committee discussions highlighted the fact that there have been any number of reports stating that there needs to be reform of primary care, but no coherent vision of what the reforms should look like.

For example, there is talk about shifting various types of long-term care for physical and mental illnesses into the "community", but there has been no discussion about what role primary care would play in such a new system. Hospitals are also very much caught up in all sorts of reforms, but it is not clear how changes in the hospitals are to fit into the broader picture.

The issue of rural health care was identified as another issue relating to primary care reform and hospital reforms. Many rural areas are severely under-serviced. There are serious problems for doctors in rural areas; they are working too hard, and they tend not to stay.

From the point of view of the Steering Committee, the MRG could contributors to articulating 1) a critique of primary care as it is now; 2) a set of principles for primary care; and 3) a model for reform.

House call services

House call services were another subject of Steering Committee discussion. There was agreement that the "med-visit" agencies specializing in house call services are draining money out of the system for a medical service that is problematic at best. These services practise no, or virtually no, triage: everyone who calls gets a house call whether one is appropriate or not. Patients are seen, and prescriptions made, but there is no follow-up and rarely a report to the patient's GP.

There was a feeling that one of the underlying problems is that family doctors are not providing house calls or after-hours service, and the Steering Committee took the position that a combination of incentives and disincentives should be put in place to encourage the provision of after-hours and on-call service by GPs.

Third party services

The government announced earlier this year that OHIP will no longer pay for most medical services requested by a third party.

The Steering Committee supported the underlying rationale that medically unnecessary services, such as sick notes demanded by employers, are not something that taxpayers should be paying for through the health care system. Employers have been taking advantage of OHIP to demand sick notes, which are a way of policing employees and have nothing to do with health care.

But the problem is that patients may wind up paying for these services instead, which will hurt those least able to afford them, e.g. medical examinations required to go to summer camp.

There is also considerable danger in setting up a system where it is considered normal to bill patients directly for some services.

Nor are there guidelines regarding what is a reasonable charge for uninsured services. Members of the Steering Committee reported hearing of instances where patients are being hit with unconscionable costs. One patient was billed $30 for a one-page photocopy of her ultrasound report.

All this is setting up the expectation that patients will pay directly for services, something already reflected in the growth of so-called "administrative charges" by some physicians.

The Steering Committee took the position that if a service is trivial, there shouldn't be a bill, and if it is billed, the bill should go to the third party, not the patient.

Ontario Health Coalition

The Ontario Health Coalition has been active on a number of issues, including public opposition to cutbacks in federal transfer payments for health care. Two members of the MRG Steering Committee have played an active role in the OHC.

Media appearances

The MRG has always sought to make its views known to the public and to members of the health professions through the media, participation in coalitions, meetings, and conferences, and any other channels that offered themselves. Members of the Steering Committee have undertaken numerous speaking engagements in the past year, both in Canada and the U.S., and have appeared on panels at public meetings and on television and radio programs. A number of MRGers were featured in the film *Doctor to Doctor*, to be shown at the fall general meeting. Members of the Steering Committee have been sending off letters to the editor regularly to comment on issues, and have written a number of "op-ed" articles for newspapers. Some of these media appearances have been noted in past issues of *Medical Reform.*

Cold shoulder

The MRG has also sought to make its views known to government, through periodic meetings with the Minister of Health and with other health ministry officials. MRG representatives had regular meetings with both Progressive Conservative and Liberal Ministers of Health, as well as with previous NDP Health Minister Frances Lankin.

The Steering Committee has tried repeatedly to get arrange a meeting with the present Health Minister, Ruth Grier, hoping to urgently put forward its position on how cost savings in health care could be achieved *without* compromising the quality of care. There has been no response or acknowledgement of the MRG's phone calls and letters from the Minister's office.

NDP government

While the MRG has stated its support for some of the initiatives undertaken by the NDP in the health care field, there has also been serious criticism of what the government has been doing. The June general meeting heard criticisms from many MRG members about the direction now being taken by the government.

As summarized by the Steering Committee in an "op-ed" article, these criticism are that (a) the government

Continued on page 8

Steering Committee Update
Continued from page 7

lacks a coherent vision or strategy for what it is trying to do with the health care system; (b) the reforms to the health care system have been poorly planned and badly managed; (c) some of the NDP's actions contradict its own stated principles and policies; (d) some of the government's measures are causing, or will cause, as many problems as they solve; (e) there are better alternatives available, which are more rational, more effective, and more equitable.

BC Agreement

The Steering Committee looked the recent agreement between British Columbia's NDP government and the BC Medical Association, anticipating that some of the BC measures will be adopted by other provincial governments, including Ontario's, sooner rather than later. The British Columbia agreement provides that if a patient wants a procedure which the physician feels is not medically necessary, then the patient, rather than the health plan, has to pay for it.

There were differing "takes" on the Steering Committee as to how one defines what is medically necessary and who decides. It was recognized that there will always be a "gray area", and that there should be some room for consideration of the patient's psychological distress.

There was agreement that all effective medical services should be free, and that where there are clear indications physicians should be given guidelines and professional standards.

The Steering Committee's consensus was that if a physician feels that a procedure is medically necessary, then it should be covered by the provincial health plan. If the physician, informed by medical guidelines and his/her judgement, believes that the procedure would be useless or harmful, then it should not be available, even if the patient is willing to pay for it.

There was a strong feeling that once there is a category of services which are available to those willing and able to pay, that sector will inevitably mushroom. Doctors will have a strong incentive to shift patients into the direct-pay category to augment their incomes, while governments will have an equally strong incentive to do the same thing as a way of shedding costs. The Ontario government has already de-listed a number of procedures.

Refugee claimants

The provincial government has announced that it will no longer pay for health care for refugees claimants. It states, correctly, that the federal government is responsible for paying their expenses. The Steering Committee agreed that this is legally a federal responsibility, but expressed strong concerns about the fact that while this is being sorted out, refugee claimants are being denied access to health care unless they can afford to pay for it, which most can't. Some of the most vulnerable and powerless people are being hurt.

On a similar matter, it was also reported that pressure is being exerted by provincial officials to take individuals off provincial social assistance and put them on federal disability benefits. However, the federal disability plan pays less, so the welfare of those affected may be compromised in the interests of cost reduction.

Steering Committee

The MRG Steering Committee currently consists of the following people: Mimi Divinsky, Murray Enkin, Gord Guyatt, Chris Jinot, Haresh Kirpalani, Rosana Pellizzari, Ian Scott, Jim Sugiyama, Vera Tarman. MRG members are invited to attend Steering Committee meetings to observe, take part, or even to help them decide whether they would like to join the Steering Committee. New Steering Committee members **are** needed to bring the Steering Committee up to full complement. If you think you may be interested, call the MRG at (416) 588-9167 or come attend one or two meetings. Meetings are monthly, and alternate between Toronto and Hamilton.

NEWS BRIEFS

Abuse by nurses found

A survey of 1,608 nurses by the Ontario College of Nurses found that nearly half those polled had witnessed at least one incident of physical or verbal abuse of a patient by another nurse. Half of those said they had witnessed "numerous" incidents. Two-thirds of the reported incidents involved elderly patients. Ten per cent of the reported incidents involved hitting or shoving, 31% "roughness", 28% yelling and swearing, and 28% embarrassing comments. Respondents said patient actions precipitated about 70% of the incidents. The survey did not specify a time period, so there was no indication of how many of the incidents occurred in a given period of time. The College is moving to develop a public awareness program and professional guidelines.

-25 September 1993

New Brunswick to privatize administration of health care system

New Brunswick Premier Frank McKenna has announced that New Brunswick's Liberal government will turn over administration of the province's medicare plan to the private sector. Premier McKenna claimed that by handing the administration to a consortium of private companies, the province will save between $12 and $60 million a year.

Apparently unconcerned with the government's bargaining position in negotiations with the private consortium, McKenna made the announcement before the government had even received a firm proposal from the consortium.

About 80 government employees will lose their jobs. Some will be hired by the private consortium at undetermined wages.

The government also announced that it will introduce a personal health card which will be used to feed information into a centralized computer system run by the private consortium. The new system is supposed to help the province track down abusers of the system. The cards will also allow instant printouts of the cost of medical services. The intent is to give each patient a statement showing them the cost of their health care.

29 September 1993

Non-profits to be favoured

Ontario Health Minister Ruth Grier has announced that the government will move to diminish the role of for-profit operators in the provision of long-term care. "The role of for-profit organiza-

tions will diminish to 10 per cent of the amount of service that is provided over the next two or three years," Grier said in commenting on a report offering a blueprint for long-term care in the province. Grier said that the aim of the new system is to co-ordinate the 1,200 agencies that provide services for the chronically ill into a new system that will aim at keeping people in their home longer, with one-stop access to services. The agencies will be umbrella organizations working under the guidance of Ontario's 32 district health councils. The agencies will combine home-care and placement co-ordination with the existing services of community groups, such as personal care nursing, home-making, physiotherapy, telephone support and transportation. Grier said some of the new agencies will be operating by 1994, with the remainder coming on stream in 1995.

-30 September 1993

"Administrative fees" may go

Ontario doctors could be barred from charging patients yearly so-called "administrative fees" by the end of the year. The Ministry of Health has announced that it intends to move against the charges, which are supposed to be for services not paid for by OHIP, such as renewing prescriptions by phone or writing letters on behalf of patients.

However, Dr. Michael Dixon of the College of Physicians and Surgeons of Ontario, warned that the move could actually result in some patients having to pay more, since MDs will still have the option of billing individually for each uninsured service.

-16 October 1993

Liberal platform

According to statements made by Jean Chretien during the election campaign, his newly elected Liberal government will not allow the introduction of user fees in Canada's health care system. The Liberal policy document also stated that "a comprehensive re-examination of Canada's health-care spending is required." The Liberals have said nothing about whether they intend to maintain, or change, the existing Progressive Conservative legislation which is aimed at the elimination of all transfer payments to the provinces for health care by about 2002.

Membership renewal

The Medical Reform Group's new membership year began October 1. You should have received your membership renewal notice about three weeks ago. 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 associates (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

MRG Fall Meeting

The Medical Reform Group's fall general meeting will be held on Thursday **November 4** at 6:50 pm at the Davenport-Perth Community Health Centre, 1900 Davenport Road, in Toronto. The featured speaker will be David Naylor of The Institute for Clinical Evaluative Sciences. For more information contact the MRG at 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

Nurse Practitioners

A discussion paper on the utilization of nurse practitioners prepared at the request of the Ministry of Health may mean the role of nurse practitioners is back on Ontario's health care agenda.

The paper recalls that educational programs initiated in the 1970s to prepare nurse practitioners were ended in 1983 "as a result of an oversupply of physicians in urban areas, lack of career opportunities, lack of appropriate remunerative mechanisms, and attitudinal barriers on the part of some physicians".

An analysis of studies evaluating nurse practitioners in primary health care "found they achieved equivalent outcomes to or scored more favourably than physicians on most variables". "Numerous studies have established the economic efficiency of NPs. They have been shown to reduce the use of ambulatory and emergency room services, decrease hospital utilization rates, reduce radiology and lab costs without changing illness outcomes, and increase the use of non-drug therapy."

The report recommends steps to re-establish nurse-practitioners, including establishing a steering committee representing all the stakeholders; identifying settings where there is a need for NPs; defining their role; addressing potential barriers; determining the number and ideal mix of NPs, physicians and other health care professionals; defining the educational preparation required; and developing performance indicators to permit ongoing assessment.

In the short term, public health nurses/nurse practitioners "should be utilized fully in primary health care practices which use salary or capitation methods of reimbursement (e.g. CHCs, HSOs), in under-serviced areas and in the care of the disadvantaged. Once the number of family physicians is reduced and the fee-for-service system of reimbursement is replaced with salary or capitation, PHN/NPs could take on a more active role in the delivery of primary health care services." High priority settings are identified as mental health, gerontology, long-term care, oncology, cardiac care and pediatrics.

Utilization of Nurse Practitioners in Ontario, by Alba Mitchell, Janet Pinelli, Chris Patterson, and Doris Southwell. School of Nursing, Faculty of Health Sciences, McMaster University, Hamilton, Ontario.

Bitter harvest in Vietnam

There is a small store room on the first floor of Ho Chi Minh city's Tu Du obstetrics and gynaecological hospital which its nurses are reluctant to enter. Vietnamese superstition has it that you may be possessed by the image of calamity. The store room holds the nightmarish evidence of a continuing tragedy that has implications for all industrialized countries.

The shelves around its walls are lined with large laboratory jars containing fetuses, some with two heads, or a single Cyclopean eye, most with grotesquely withered or twisted torsos and limbs. They are preserved as terrible witnesses to what Vietnamese doctors are convinced are the effects of Agent Orange.

U.S. forces and their allies sprayed more than 18 million gallons of this and other chemical defoliants across 6,500 square miles of southern and central Vietnam during the war in an attempt to deny forest cover to their elusive enemies. The spraying covered 44 per cent of Vietnam's forests, some of them several times. Large tracts of what was once thick jungle are still bare of any vegetation except coarse grass. But more disturbing has been the consequences for people living in the areas sprayed.

Most potent and most widely used of the defoliants during nine years of spraying was Agent Orange, manufactured by a consortium of seven American companies and based on a highly toxic dioxin. Admiral Elmo R. Zumwalt, the commander of U.S. naval forces in Vietnam during the latter stages of the war, has noted that American troops sprayed Agent orange at concentrations up to 25 times greater than considered safe for human use even by the lax standards of the time. Now, 23 years after the spraying stopped, doctors at Tu Du Hospital are wrestling with what they believe are its hideous consequences for mothers and their children.

Last year, Tu Du Hospital alone treated 833 women for molar pregnancies, a condition leading to chorio carcinoma, a form of cancer attacking unborn babies, and twice that number suffering tumours. About half were aged between 18 and 25, all came from areas sprayed by the Americans. The great majority survive; if their cancer is caught early enough they may be able to raise a family. But many come too late and the operations they undergo leave them unable to have children. In most cases, Vietnamese doctors say husbands will abandon a woman who cannot give them children.

Many of the molar pregnancies end in abortion but staff in Tu Du Hospital, which delivered more than 21,760 babies last year, say more than two per cent are born with deformities. Few of the deformed babies survive long, nurses say, but a recently added wing of the hospital now houses more than 30 deformed infants who will be kept a number of years until they can be sent to an orphanage.

After more than 20 years of treating these diseases, Tu Du's Dr. Nguyen Thi Ngoc Phuong is utterly convinced the cause of the cancers attacking her patients is Agent Orange. Studies by Vietnamese doctors and R. Arnold Schecter, professor or preventive medicine at the State University of New York, have revealed dioxin stored in human fat and breast milk at far greater levels in the south of Vietnam, where spraying occurred, than among the population of the north, where it did not. The studies "suggest a relationship between Agent Orange exposure and elevated levels of primary liver cancers, soft tissue sarcomas, spontaneous abortions and genital malformation," Dr. SChecter told a U.S. Congressional hearing. But the nature of that relationship has still not been conclusively established.

"There are a lot of gaps. These sort of findings have not been reproduced in other groups where you might expect that effect to appear," says Alistair Hay, senior lecturer in chemical pathology at Leeds University. "It seems that what the dioxin is doing is acting as a promoter, exacerbating the effect of cancers that may arise from other causes."

Dr. Schecter believes further research in all aspects of the impact of dioxin is urgently needed and Vietnam would be the most telling testing ground, but there has been no funding, another casualty of the war. For Dr. Phuong and her Vietnamese colleagues, the priority is to save patients.

Dr. Schecter has travelled 10 or more times to Vietnam to do research financed exclusively by private donations representing a mere five or 10 per cent of what is needed to do a thorough job. But the U.S. government, preoccupied with holding Hanoi to account for America's dead and missing in the war, has sustained an economic embargo on Vietnam which, until recently, blocked aid for research.

Even within the U.S., the government has never conducted a comprehensive epidemiological study of the effects of Agent Orange exposure on veterans, fuelling a bitter controversy. Some 36,000 veterans have registered for compensation for health problems ranging from cancers to reproductive difficulties and birth defects, skin diseases and urological disorders. But until recently government, industry, and the military denied any causal link with Agent Orange.

Veterans claim successive administrations deliberately frustrated investigations to deflect claims for compensation. After a review of available studies Admiral Zumwalt concluded that government and industry "intentionally withheld or manipulated compelling information of the adverse health effects associated with the exposure to the toxic contaminants contained in Agent Orange." His accusations have a particular poignancy. As naval commander in Vietnam from 1970 to 1974 he ordered widespread spraying of Agent Orange. His son, a patrol boat commander at the time, died five years ago of cancer believed to be linked to his exposure to the defoliant and a grandson suffers from birth defects.

Recent studies are beginning to tip the argument towards the veterans. The Bush administration agreed two years ago to pay compensation to veterans for two forms of cancer. Last year research in the U.S. and Europe, prompted by wider concerns about the danger posed by dioxins to the environment and to workers, has established a probability that dioxin indeed produces cancer in humans. Meanwhile, moves to relax the U.S. embargo on Vietnam are also opening up the prospects of properly financed research. Dr. Schecter for the first time will apply this year for federal government funding to study the impact of dioxin there.

The costs are high: Dr. Schecter is seeking $2.5 million a year for up to six years to study the movement of dioxin in the environment and a like amount to research the effect on health. The result, he insists, would fully justify the expense. "It would be helpful to people in industrial countries all over the world as well as in Vietnam. Are we over or under-reacting to the threat of dioxins? This would give an answer."▼

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