MEDICAL REFORM

Newsletter of the Medical Reform Group

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

Volume 14, Number 3 — July 1994

Holdback formula penalizes low billers, MRG says

The Medical Reform Group's Steering Committee issued a statement opposing the "holdback" formula adopted recently by the Ontario Medical Association Council. The MRG's statement as it was released to the media appears below:

In a decision as undemocratic as it is unwise, the Ontario Medical Association Council has decided on a formula for a Social Contract "holdback" which penalizes lower-billing physicians, including those who take extra time with their patients.

The holdback flows from the OMA's agreement with the Ontario government. This agreement stipulates that physicians must adhere to a billing cap of approximately 3.9 billion dollars. Physicians' billings are expected to be about 2 per cent over that cap in the 1994-95 fiscal year, and so a holdback is required. It is up to the OMA to determine how this holdback should be distributed among physicians.

The OMA surveyed its membership regarding distribution of the holdback. Over 10,000 members responded. The membership strongly supported a sliding scale based on income. This would mean that higher-billing physicians would have more than 2 per cent of their billing held back, and lower-billing physicians less than 2 per cent.

OMA council ignored the results and chose an across-the-board holdback based on gross OHIP payments. This means that each physician will lose 2 per cent of her or his gross income.

Continued on Page Two

INSIDE

Giving birth to propaganda

One of the tactics of the anti-medicare campaign being waged by the corporate media in the United States is to publish "exposes" of the allegedly disastrous Canadian health care system. These exposes are eagerly picked up by Canada's corporate press as they press on with their own campaign to bring the benefits of privatization and the free market in health care to skeptical Canadians.

One recent example was an article in the Wall Street Journal, titled "Don't Give Birth Up Here", which claimed that conditions in Canadian maternity wards are primitive. The article was picked up and given prominent play by the Globe and Mail.

Two MRG members wrote a reply which appears below:

As two physicians involved in the care of mothers and infants in Ontario — one a family practitioner with a large obstetric practice in Toronto, the other a specialist in neonatal intensive care in Hamilton — we were appalled by the distortions about health care in Canada in a recent *Journal* article (Don't Give Birth Up Here). As your readers

Continued on Page Two

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.
E-Mail: UDiemer@sources.com

Opinions expressed in Medical Reform are those of the writers, and not necessarily those of the Medical Reform Group.

Editorial Board: Haresh Kirpalani, Gord Guyatt, Lena Fung, Ulli Diemer.

Production by AlterLinks (416) 537-5877.

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

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

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

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

Giving Birth to Propaganda

Continued from Page One

consider the options for health care reform, we certainly hope they look to more reliable sources than the Journal for their facts about the Canadian system.

Canada has one of the finest records for maternal and infant care in the world. Epidurals for pain during labour are routinely given, as they are in the U.S. However, U.S. statistics on prenatal care, infant mortality, and maternal mortality are the worst of any developed nation other than South Africa. Whose system is "primitive"?

We are happy to hear that one U.S. writer had private insurance that paid for her delivery and epidural. Millions of women of reproductive age in the U.S. have private insurance policies that specifically exclude maternity care. Many more have threadbare policies that exclude coverage of newborns, putting a family at risk in the case of a problem.

In Ontario, every woman is covered for comprehensive medical care during pregnancy and delivery; all infant care — from the most highly specialized intensive care to routine immunizations — is also covered.

The expansion of midwifery and birthing centres is aimed at improving our already enviable record in delivering outstanding medical care during pregnancy and delivery. Recent cost-control measures have not affected the availability of proven beneficial measures. The same cannot be said in the U.S., where the tragically high incidence of low birthweight babies is directly linked to your lack of early prenatal care.

We suggest that the *Journal* carry a series of articles with more accurate information about the Canadian health care system. We would be happy to facilitate this urgent task.▼

Haresh Kirpalani BM, MRCP,
Associate Professor of Pediatrics
McMaster University Medical Centre,
Hamilton
Rosana Pellizzari, MD, CCFP
Davenport Perth Community
Health Centre

Holdback Formula Penalizes Low Billers

Continued from Page One

The Medical Reform Group, a group of physicians which is critical of the distorting effects of the fee-for-service system of physician remuneration, strongly condemns this undemocratic decision by the OMA Council. "The decision will be demoralizing for the most conscientious physicians who are already under considerable stress," said MRG spokesperson Dr. Gordon Guyatt, "and therefore could potentially compromise patient care."

For the *Hamilton's Spectator's* coverage of the issue, see page 4.▼

SYLVIA **by Nicole Hollander**

The political use of patients

Members of the Ontario College of Family Physicians were recently sent a letter by Dr. Rick Mann, President of the College, expressing concern about proposals regarding the utilization of nurse practitioners. Dr. Mann suggested that physicians talk to their patients about this issue, and make petitions and sample letters available in their offices for patients to sign.

The Medical Reform Group was asked to respond to this suggestion that physicians should enlist their patients in a political cause. (See letter by Alba Mitchell in this issue.)

The Steering Committee's discussion quickly yielded stories of other incidents involving the political use of patients. Steering Committee members view such activities as an inappropriate overstepping of the boundaries of the doctor-patient relationship.

To get an idea of how extensive this kind of thing is, we are asking MRG members and readers of *Medical Reform* to send us examples which they have encountered. Your stories are solicited. We would also especially welcome examples of posters, letters, and other propaganda aimed at patients in doctors' offices. Your thoughts and comments about what is appropriate and what is inappropriate would also be appreciated.

Send your stories, thoughts, posters and other materials to:

Medical Reform, Box 158,
Station D, Toronto, Ontario M6P 3J8,
Fax: (416) 588-3765;
E-Mail: udiemer@sources.com

Welcome Nurse Practitioners

The Minister of Health recently announced that Nurse Practitioners would be trained and licensed in Ontario. This development has come in the wake of increasing scientific support for the role of Nurse Practitioners and the growing momentum for primary health care reform in this province.

The Medical Reform Group of Ontario, representing 200 physicians, applauds this move by the Ministry as a significant step towards a system which promotes wellness and imparts the skills and knowledge necessary for consumers to make better decisions and choices. We also support the College of Family Physicians' assertion that "well-trained nurse practitioners can and, in some cases already do, complement the comprehensive care provided by physicians in community and family practices" (Press release, March 2, 1994)

Many Ontarians have already experienced the benefits of an interdisciplinary primary health team. Users of Community Health Centres(CHCs) and Health Service Organizations (HSOs) are familiar with Nurse Practitioners, whom they may see for minor illnesses, family planning, health education, and "wellness" care such as annual pap tests for healthy women, well baby visits etc. Currently, in these settings, Family Doctors, in turn, address the more complex diagnostic and treatment issues.

Symptoms of illness and disease are often provoked or amplified by emotional and psychological overlays. Whether people have jobs, the quality of their relationships, their housing, their coping mechanisms all impact on their perception of well-being or illness. Regardless of the "presenting complaint" or the "reason for the encounter", we all share a responsibility to address these determinants of health as we work with and care for individuals and families.

Deploying health professionals in settings which recognise and utilize their training, skills and knowledge in the best match with consumer needs results in a more efficient, more effective primary care system. Emphasizing health education and health promotion should also reduce the overdependency on the illness system for medical solutions to trivial or inappropriate problems. Committing resources and creating strategies to address the determinants of health should help to prevent problems before they arise. The "medical model" of the past just doesn't make the grade for the 21st century.

The challenge, as the College of Family Physicians clearly identifies, is to "facilitate integration" by transforming our present unsystem of primary care into a coordinated and accountable system which will foster health and treat illness effectively and appropriately. This new system will look very different. To Nurse Practitioners, we say "Welcome!"▼

Rosana Pellizzari, MD, CCFP
Member of the Steering Committee,
The Medical Reform Group

The above was sent as a letter to the editor of the Globe & Mail

Questionable tactics on nurse practitioner issue

I would like to bring to the attention of the Medical Reform Group a letter from Dr. Rick Mann, President of the Ontario College of Family Physicians to the members of the College. His letter is in response to Ruth Grier's announcement about the utilization of nurse practitioners in Ontario.

Dr. Mann's major concern with the announcement is the Minister's support for nurse practitioners working "independently". While I can understand his concern about this issue, it is not one worth much time and effort because very few nurse practitioners will choose to set up private practices. In the United States, less than 3 per cent of all nurse practitioners work independently. Those currently working independently in Ontario are those in underserviced areas working alone not through choice but because few physicians choose to work in these remote areas.

My specific concern with Dr. Mann's letter is his recommendation to his colleagues that they talk to patients "who can be tremendous allies" and his offer to provide a sample open letter to patients as well as a petition which physicians might make available in their office and then forward to the Minister. It is this issue I would like to draw to the attention of the Medical Reform Group. I am concerned that the strategy of enlisting patient support through the physician's practice might exploit the patient-physician relationship and leave patients vulnerable to feelings of pressure to sign a petition even if they may not entirely agree with it.

I would appreciate the MRG's opinion of whether it is a violation of the patient-physician relationship for physicians to talk with their patients, to give them a letter and/or to make a petition available in their offices, related, in this case, to concerns about non-physician health care providers. If so, I would like to recommend that the MRG be the group to respond to Dr. Mann to help him understand the possible impact of his suggestions on patients.▼

Alba Mitchell

2% billing holdback undemocratic: MDs

By Suzanne Morrison

A plan by the Ontario Medical Association to ask all doctors in the province to contribute equally to overbilling under the social contract is undemocratic, say members of the Medical Reform Group.

In a news release yesterday, the MRG said, even though OMA members had strongly supported a sliding scale based on income, the OMA council still decided on a 2 per cent holdback for all doctors.

"OMA council ignored the results and chose an across-the-board holdback based on gross OHIP payments. This means that each physician will lose 2 per cent of her or his gross income," it says.

The MRG argues this formula for a clawback of doctors' earnings penalizes those who bill OHIP the least, including those who take extra time with their patients.

Dr. William Orovan, past president of the Hamilton Academy of Medicine and delegate to the OMA council, said it's not true some doctors will be hit harder than others because those earning less will pay less.

A sliding scale was one of several options council debated strongly for a full day, Dr. Orovan said, adding it felt a sliding scale would be "extremely punitive to some hard-working doctors and would drive away from the province many of the specialists who we are already losing in large numbers."

Other choices, he said, had serious problems and would have required government legislation.

The 23,000 physicians in Ontario earn an average of $180,000 a year.

There are about 1,000 doctors in Hamilton, which could mean a significant clawback from the area, beginning this month, Dr. Orovan said (rough estimates, based on 2 per cent holdback each month for 1994-95, suggest it could add up to over $3 million).

Dr. Gordon Guyatt of Hamilton, an MRG spokesperson, believes young physicians just starting to build practices, or people taking time off, will suffer most.

He said the OMA turned down alternative proposals that would exempt some physicians, in favour of the across-the-board formula.

If nothing else, the OMA decision "has the merit of simplicity," he said.

Continued on Page Five

2% Billing Holdback...
Continued from Page Four

Dr. Jennifer Everson, a family physician in Ancaster, said the whole system of clawbacks is wrong and the OMA has to start looking at it with the government.

"I think over the next couple of years there will be a completely different system because this isn't going to work."

The holdback issue stems from the OMA's agreement with the Ontario government that stipulates doctors must adhere to a billing cap of $3.8 billion a year.

Jean Chow, OMA director of public relations, said under the social contract there has been a 4.8 per cent holdback of doctors' monthly billings to OHIP from October 1993 to March 1994, the end of the fiscal year, to meet the cap.

Although final figures won't be available until November, it's anticipated that doctors have exceeded their cap by 0.5 per cent and will have to pay it back.

The coming year's 2 per cent holdback is an effort to keep doctors' billings within the $3.8-billion cap for fiscal 1994-95.▼

Reprinted from the Hamilton Spectator, July 8, 1994

Costly drugs overprescribed, study finds

By Rod Mickleburgh

TORONTO—Ontario physicians are prescribing vastly more expensive drugs for the elderly, often with little regard to their relative effectiveness, according to a landmark study released yesterday into medical practices in the province.

Spending on gastrointestinal and cardiovascular drugs for the elderly more than tripled in Ontario from 1985 to 1993, while spending on drugs to treat prostate cancer among the elderly virtually doubled from 1990 to 1993.

The study said the introduction of new, expensive drugs accounted for most of the increase, yet there was little evidence that these drugs were significantly better than existing medications.

Joel Lexchin, an expert in drug-prescribing practices, said the findings indicate the success of promotion and marketing techniques by pharmaceutical companies.

"Doctors are willing to prescribe drugs which are more expensive, but which aren't any better medication," Dr. Lexchin said. "I think doctors are very influenced by the promotion of these drugs."

David Naylor, president of the Institute for Clinical Evaluative Sciences, which conducted the study, said rising drug costs require urgent attention. "Spending on drugs is growing faster than any other health-care sector. But remarkably few new drugs are breakthrough drugs. There's a pressing need to get at the matter of drug utilization."

In the report's chapter on prescription drugs for the elderly, researchers used data from the Ontario Drug Benefit Plan, which pays for all approved drugs for residents over 65.

In an interview, Dr. Lexchin said the "grossest example" of inappropriate prescribing uncovered by the institute occurred among five specific drugs used to treat stomach ulcers and esophagitis.

The study found that spending by the provincial drug plan on the oldest and cheapest drug, cimetidine (14 cents a dose), actually declined from $2.41-million in 1985-86 to $1.53 million in 1992-93.

Meanwhile, spending on the most heavily prescribed drug, ranitidine (90 cents a dose), shot up from $10.35-million in 1985-86 to $39.04-million in 1992-93. The most recent and expensive drug, omeprazole ($2.28 a dose), cost the drug plan more than $ 12-million in 1992-93 up from $2.45-million two years earlier.

"Cimetidine has been out the longest," Dr. Lexchin said. "It's the cheapest of the five drugs.

"And for 85 per cent of patients, there's no reason to prefer any of the others over cimetidine." Side effects of cimetidine are worrisome for the remaining 15 per cent, Dr. Lexchin said, but it is relatively easy to determine which patients shouldn't use the drug.

" However, the marketing campaign of Glaxo [which manufactures ranitidine under the trademark Zantac] has been very effective at convincing doctors to switch," he charged. "They've played on the side-effects issue."

Continued on Page Six

Costly Drugs Overprescribed

Continued from Page Five

Dr. Naylor noted that shifting only 50 to 60 per cent of prescriptions from ranitidine to cimetidine would save $ 15-million a year.

The study also looked at four major categories of drugs used to treat hypertension and overlapping forms of heart disease.

Diuretics and angiotensin-converting-enzyme (ACE) inhibitors are prescribed for hypertension and congestive heart failure, while beta-blockers and calcium-ion antagonists are used to combat hypertension and angina.

As with the gastrointestinal drugs, the more expensive drugs are now prescribed much more frequently than cheaper medications."

Five times more calcium-ion antagonists were prescribed in 1992-93 than in 1985-86, boosting their total cost to $92-million from $14.64-million.

Spending on beta-blockers, on the other hand, rose only from $12.74 million in 1985-86 to $19.75-million in 1992-93.

During the same period, spending on diuretics dwindled to $6.21-million from $7-million, while the provincial drug plan forked out $48.3 million on ACE inhibitors in 1992-93, compared with only $2.19-million in 1985-86.

Yet, according to the study, recent treatment guidelines by the Canadian Hypertension Society recommend diuretics as the first-line therapy for elderly hypertension, followed by beta-blockers as the second line.

Calcium-ion antagonists or ACE inhibitors were recommended only if the patient did not respond to first-line or second-line therapy.

While acknowledging there are times when calcium-ion antagonists and ACE inhibitors are appropriate, Dr. Lexchin said he believes rational prescribing patterns would greatly increase the use of beta-blockers and diuretics.

"They are the only ones shown to reduce morbidity...the cheaper ones," he said. "The other ones reduce blood pressure, true. But they've never been shown to reduce mortality."

Concerning prostate cancer, the report noted that a number of new hormonal therapies have been introduced in the past few years, driving the provincial drug plan's costs for drugs for the condition from about $8-million in 1990 to $15.4-million in 1992. "These new therapies are expensive, [but] there is no clear agreement as to which new drugs or drug combinations may be most effective."▼

Reprinted from the Globe & Mail, *May 26, 1994*

A triangular concept of the ethics of health care delivery: Access, Autonomy, and Cost Containment

By Jason J S Barton

Health care is not a typical economic commodity. It is also considered a human right, a status acknowledged by the World Health Organization[1] and the Universal Declaration of Human Rights[2]. This status creates ethical dimensions in the provision of health care that are distinct from the provision of other goods and services in our society. Understanding why health care is a right and what ethical issues are involved is the key to the creation and maintenance of a good health care system.

Many of the ethical controversies regarding health care delivery can be conceptualized in terms of a triangular relation between three primary issues: access, autonomy, and cost containment. Each issue places demands on a health care system which may conflict with the demands of the other issues. A successful health care system must achieve a satisfactory balancing of the tensions generated by such conflicts. Possible changes in our system such as user fees, imposed clinical guidelines, and multitiered care should be analyzed in terms of their impact upon the tensions of this triangle.

1. Why is health care a right?

This has been discussed in detail elsewhere[3,4]. The first point to establish is that health care systems do not provide health as defined broadly by the World Health Organization: "a state of complete physical, mental and social wellbeing, and not merely the absence of disease and injury." This state of well-being requires the involvement of other societal agencies concerned with education, environment, the economy, and so on: in fact, it could be stated that this 'complete well-being' of citizens is the proper aim of all structures of society. The mandate of health care systems is more limited to dealing with disease and injury[5], both through prevention and treatment.

The argument for health care as a human right is approximately as follows. Human rights in general concern the preservation of both life and freedom of choice in life. This self-determination can be restricted if opportunities for exercise of free choice are limited. Inequalities in opportunity are a form of injustice: 'all men are created equal' refers to all persons having equal opportunity for self-fulfillment. Disease and injury can both threaten life and impose limitations on the possibilities in life (i.e. blindness, paraplegia). All persons are therefore entitled to measures that can mitigate against these effects of disease and illness. When health care became effective against disease and injury (a relatively recent phenomenon[6]) it became a right.

This argument implies two elements to health care as a human right. First there is preservation of life. Death is an 'absolute loss' of freedom of choice. Life-saving health care must have absolute priority in any system. Second, there is preservation of opportunity. The 'relative loss' of opportunity from non-fatal disease or injury is a spectrum ranging from the temporary and trivial (i.e. common cold) to the permanent and tragic (i.e. quadriplegia). "Relative need" arguments say that greater impairments have greater claims on limited resources, when resources are effective[7]. Thus this second element of health care may have a utilitarian view not applicable to the first. Weighing need by the handicap caused by disease is a complicated means of allocating scarce resources, but it is consistent with the reasons why health care is a right.

2. Access

If we accept the argument that health care is a universal human right, then it follows that access to health care should be available to all people. All industrialized nations except the US and South Africa have recognized this by providing a national health care system for their citizens. The Hall Report, the foundation of our health-care system, urged that "...we now take the necessary...decisions to make all the fruits of the health sciences available to all our residents without hindrance of any kind. All our recommendations are directed towards this objective."[8]

The Universal Declaration of Human Rights gives health care equal status to food, shelter and clothing. The supply of the latter in our society is through the free market (with shortfalls made up by charitable or governmental organizations). However, health care differs from food and clothing in several ways. Health care is an episodic and unpredictable need. Individuals are seldom responsible for incurring this need, with heredity, environmental factors and 'chance' playing a large part in bringing on illness[9]. Health care is expensive: as a result its supply is limited and asking charity and government to provide for

those who can't pay is unrealistic and creates other inequalities. The costs of health care can be as unpredictable and catastrophic as the illness.

As a result, third-party payment must ultimately be involved in a health care system that guarantees universal access. In our expensive times, universal access *is* universal insurance, despite claims to the contrary[10]. However, the cost-benefit judgments that occur in market purchases are distorted with third-party systems, since at the point of utilization one consumer (patient) compares benefits without regard to cost and the other (insurer) compares costs without regard to benefit. Increasing costs and competition drive American private insurers to minimize expenses by denying insurance to and excluding conditions in people most likely to use health care. The interests of private insurance do not lie in providing universal access to health care. Such access requires either laws to force it on profit-motivated insurers (i.e. Dutch or German regulation[11]) or a service-motivated and publicly accountable insurer (i.e. the Canadian government).

Access is also more than money[12]. The Canadian system has removed financial barriers but other problems remain. The under-supply of health care in rural areas is another ethical issue of access. Racial and cultural barriers among immigrants and natives may exist in areas with adequate services[13], which may be improved through social services and education.

The ethical drive from 'access' is towards equal provision of health care to all persons, in respect to need and regardless of ability to pay. Equal access must be provided to services that preserve life or improve opportunity in life effectively.

3. Autonomy

Individuals should be free to determine their course in life and partake of the consequences of their actions. If health care is seen as important in maintaining opportunities for this exercise of free choice, it is also important that individuals be allowed free choice within the health care system. First, patients deserve autonomy. In practice the most important choice patients make is often their choice of health care provider. In contrast to other market transactions, where consumers make their own cost-benefit judgments, the knowledge of benefits and costs in health care lies primarily with the providers rather than the consumers. The complexities of medicine guarantee that the provider has great influence in the treatment decisions of the patient[14]. Medical codes of ethics and the concept of physicians as patient advocates are responses to this fact. Thus patients must have the right to choose their provider, a right recognized in the Hall report[15].

Second, health care providers require autonomy in directing care freely in concert with and on behalf of patients. This is a consequence of the role of physicians as patient advocates and in part an extension of patient autonomy. Providers must be free to select care according to the needs of the patients, without reference to external considerations. A full range of effective therapeutic options should also be available if such freedom is to have real meaning.

The ethical drive from 'autonomy' is towards providing patients with free

PATRICK CORRIGAN / TORONTO STAR

choice of practitioners and providing patients and physicians with unlimited supply of effective health care services for opportunity-limiting conditions, without external constraints on choice.

4. Cost containment

Ethics often concern hard choices among limited options: when resources are finite and needs or wants seldom are, ethics inform our allocation of these resources. Cost containment becomes an ethical issue as any dollar spent on health care is a dollar taken away from other social programs, and any dollar spent on transplants is a dollar taken away from dialysis and prenatal care. Economic cost-benefit analyses must be placed in an ethical context, as a branch concerned with the efficient use of resources.

A good health care system should provide all persons with access to life-preserving treatments. However, many diseases reduce opportunity (morbidity) without being fatal. The cost of providing all conceivable therapies that could restore opportunity may well be infinite. How do we decide what to provide? The principle of relative need is likely the only rationing coherent with the ethical basis of health care. Those with the greatest reduction in opportunity and for whom resources are most effective have the greatest claim[7]. In practice, though, there are daunting obstacles. How does one compare the impact of diseases and therapies on opportunity without dealing in apples and oranges? How do we measure efficient use of resources? Yet the price of ignoring this part of the triangle has been the rapid escalation of health care costs to the point where universal access and autonomy may be imperiled by proposed changes.

There are two considerations. One is the "cost-efficiency" of our allocations: how much service do we get for our dollar? The single payer Canadian system offers significant savings in administrative costs when compared to a system of multiple payers[16,17]. Yet, despite the hopes of some[14,17,19], it is unlikely that efficiency savings alone will banish rationing. The second consideration is the "cost-efficacy" of our allocations how effective is the service we get ? If we cannot afford everything, we cannot afford ineffective therapies. Tests and treatments of dubious benefit are provided today, yet the use of new and expensive technologies grows without systematic analyses by the health care system of the costs and benefits of such use.

Ideally cost-efficiency and cost-efficacy should factor into decisions of what services are provided. Lacking these measures, systems can control costs by providing all services only to some (access rationing) (USA), or by providing all services to all, but in limited amounts (queue rationing) (Canada). Queues have been defended as indications of efficient resource use[20] (idle machines or empty beds imply redundancy). The length of queues may also gauge the demand for services and aid in directing resource allocations. However, this approach to cost-containment fails ethically because of its confusion of efficiency with efficacy. It assumes that demand is correlated with benefit, whereas in truth there is only a rough approximation. The expenses involved in health care make queuing no substitute for real cost-benefit studies: the most coherent means of rationing is still by proven benefits for those most limited by ill health.

The ethical drive of 'cost-containment' is towards the provision of the least amount of services necessary at the least amount of cost to achieve the goals of the system.

5. Tensions within the triangle

Access demands that health care is universally available. Autonomy demands that patients and providers be free to determine the care undertaken. Cost-containment requires that resources be used effectively and efficiently. Any health care system can easily accommodate any two of these requirements. Without demands of equal access the constraints of cost are relaxed because there are fewer users and free choice of care is readily available to those who can afford access. Without cost-containment pressures (as in the past when medical care was much less expensive) many systems can deliver easily on both access and autonomy. It is only the introduction and growth of a third apex in both these scenarios which generates tension and conflicting demands that require balancing. Three short examples follow of how issues in health care delivery can be formulated in terms of this triangle.

a) Choice of care

One of the arguments against egalitarian health care systems in that they infringe upon freedom of choice. Currently the Canadian system does not exercise direct control over the decisions of providers or patients. However, when the single payer is also the single provider of the technology and facilities that generate cost, there is pressure to reduce costs by limiting facilities. Limiting services can be an indirect means of limiting autonomy, if effective services are not provided or not available in timely fashion. The control of the availability of services thus develops into an ac-

cess-imposed tension between cost-containment and autonomy.

Free market systems are seen as the best means of promoting freedom of choice. Such schemes preserve autonomy while relaxing cost-containment pressures by sacrificing universal access. Once universal access is introduced into such market systems, however, the pressures for cost-containment increase again. In practice the freedom of the market is also limited when third-party payers are involved. Those without insurance do not have the option to choose care. The micro-management policies of insurers can limit the options available to providers. Ultimately any thirdparty has an interest in containing costs by limiting services. The true contrast is between limitations applied unevenly to the populace by profit-motivated bodies versus universally shared limits set by publicly accountable bodies.

b) Multitiering

One proposal to ease cost-containment tensions between universal access and autonomy is a multitiered system, with a basic level of health care for all and other levels with more choice for those who can pay. For example, the Oregon experiment has created universal rationed care to supplement private (unrationed) care[21,23]. However, if health care is a right because it can restore or maintain opportunity in life, it is unjust to deny some people access to care which is available to others, since this distributes opportunity within society[21] according to ability to pay. Such tiering can only be contemplated when health care is viewed as a commodity without ethical repercussions on opportunity.

It also logically follows that services provided by health care providers which do not improve health might be provided outside the health care system. Such services should not be considered health care. Cosmetic surgery is one example, since in most cases we do not consider the 'defect' a significant handicap. Treatments shown to be ineffective for significant diseases should also be excluded from access. In fact, cost-containment considerations make it unethical to provide such services within the health care system. If these services are made available for private payment, though, it must be asked whether the system's facilities or providers trained at society's expense should be used in providing these nonhealth care services, since resources are scarce. The ethical issue thus switches from access to cost-containment.

c) Responsibility for rationing

In any system that deals responsibly with all three ethical issues of health care, decisions have to be made regarding what services should be available and who should use them. Who should decide?

Doctors, for example, already make decisions regarding who needs investigations and therapies. Ideally they weigh the costs and benefits to the patient's health as part of this process. Some suggest that they should also incorporate the economic costs to society in these decisions. However, cost-containment considerations may conflict with the physician's responsibility as patient advocate, to determine what would best improve the patient's health. Imposing the burden of this tension between cost-containment and autonomy on physicians is ethically questionable[24], as well as ineffective[4]. Although physicians should be held responsible to desist from useless practices, asking them to balance cost against the patient's interests may place them in unresolvable dilemmas.

Another candidate in a third-party payer system is the payer, since the provision of services is dependent upon someone willing to pay for their use. In contrast to providers, the payer's chief interest is cost-containment. In a multipayer system, this interest is balanced by the competitive pressure to maintain as many services as possible to attract and keep income from enrolled members. How can a competing payer keep down costs and still maintain services to attract income? The escape valve is access. Limiting enrollment to members not likely to use the system enables the payer to escape the tension. 'Access rationing' is inevitable in the unregulated multiple third-party payer system.

In a single-payer system, cost-containment interests are not balanced by a competitive pressure to maintain services. A single payer could curtail services while maintaining universal access to whatever services remain. At some point the restrictions on services will have a significant impact on the freedom of patients and providers to choose care. How can a single payer be brought to respect the autonomy of patients and providers in its rationing decisions? Most commonly the answer is to make the single payer a publicly accountable body. The payer's service mandate and the interests of the voting population (to which patients and providers belong) in maintaining services will balance cost-containment interests.

Given the importance of public accountability in balancing cost-containment pressures in a singlepayer system, it is important that the impact of the payer's fiscal policy on provision of services be clearly outlined to the public. The system will not work

if elected decision makers try to divorce cost reductions from benefit reductions. For example, it is not clear what impact arbitrary across-the-board cuts in hospital budgets will have on services: the government contains costs but the onus of reducing services is passed to hospital boards. The responsibility for benefit reduction thus diffuses away from the politicians who reduced payments. The efforts of elected officials to camouflage the impact of their decisions, while politically expedient, are ultimately unethical and irresponsible. A system that divides responsibilities and spending power between provincial and federal levels is inherently susceptible to such 'passing the buck'.

6. Conclusion

The variations between the healthcare systems of different nations can be seen as various solutions to the tensions between the issues of access, autonomy, and costcontainment. Problems arise when the balance tilts too far away from one or more of these points. The Canadian system heavily weighted access and consciously protected autonomy; however, the relative neglect of cost-containment has begun to strain the system. If this neglect continues the survival of the whole system may be endangered. The system requires better efforts at systematic cost-efficacy analysis and implementation to supplement the current cost-efficiency, as well as continuing improvements in non-financial aspects of access.▼

REFERENCES AND NOTES

1. World Health Organization, Constitution, Geneva: the Organization, 1960; p.1
2. Universal Declaration of Human Rights:Art 25. see UN Gen. Ass. Res. 217A (III). 1948.
3. Kluge EHW. Health policy and the allocation of resources: the ethics of discrimination. In: Kluge EHW. Biomedical ethics in a Canadian context. Scarborough: Prentice Hall, 1992:205236.
4. Daniels N. Justice and health care. In: VandeVeer D, Regan T, ed. Health care ethics. Philadelphia: Temple University Press, 1987:290325.
5. Evans RG, Stoddart GL. Producing health, consuming care. Soc Sci Med 1990;31:13471363.
6. An ethical framework for access to health care. In: Securing access to health care: the ethical implications of differences in the availability of services. President's commission for the study of ethical problems in medicine and biomedical and behavioural research. US Government Printing Office 1983:1147.
7. Storch J. Patients' rights, ethical and legal issues in health care and nursing. Toronto: McGraw Hill, 1984:122.
8. Royal commission on health services vol 1, Ottawa: the Queen's Printer, 1964:p.10
9. Wikler D. Personal responsibility for illness. In: VandeVeer D, Regan T, ed. Health care ethics. Philadelphia: Temple University Press, 1987:326358.
10. Todd JS. It is time for universal access, not universal insurance. NEJM 1989;321:4647.
11. KirkmanLiff BL. Health insurance values in the Netherlands and the Federal Republic of Germany. JAMA 1991;265: 24962502.
12. Ginzberg E, Ostow M. Beyond universal health insurance to effective health care. JAMA 1991;265:25592562.
13. Davis K, Rowland D. Uninsured and underserved: inequities in health care in the United States. In: McKenzie NF, ed. The Crisis in Health Care Ethical Issues. Markham: Meridian, 1990:2149.
14. Etzioni A. Health care rationing: a critical evaluation. Health Affairs, Summer 1991:8895
15. Royal commission on health services vol 1, Ottawa: the Queen's Printer, 1964:p.11
16. Barer ML, Welch WP, Antioch L. Canadian/US Health Care: Reflections on the HIAA's analysis. Health Affairs Fall 1991:229239.
17. Altman SH, Goldberger S, Crane SC. The need for a national focus on health care productivity. Health Affairs Spring 1990:108113.
18. Relman AS. The trouble with rationing. NEJM 1990;323:911913.
19. Relman AS. Reforming the health system. NEJM 1990;323:991992.
20. Naylor CD, A different view of queues in Ontario. Health Affairs Fall 1991:110128.
21. Fox DM, Leichter HM. Rationing care in Oregon: the new accountability. Health Affairs, Summer 1991:727.
22. Callahan D. Ethics and priority setting in Oregon. Health Affairs, Summer 1991 :7887.
23. Brown LD. The national politics of Oregon's health plan. Health Affairs, Summer 1991:2851.
24. Veatch RM. DRGs and the ethical allocation of resources. In: McKenzie NF, ed.
The crisis in health care ethical issues. Markham: Meridian, 1990:187207.

New Challenges for Vietnam

Vietnam is in the midst of a major economic renovation. Although the party maintains political control, the country is following China in replacing its socialist command economy with a market demand one. Its leaders and people hope that the country of seventy million people with a per capita income of just $200 a year will achieve rapid economic growth. What will these rapid changes mean for the health of Vietnamese people?

The Socialist Republic of Vietnam has made remarkable improvements in health since the end of the civil war in the mid seventies. In the years shortly after Alma Alta, when "Health For All" was a meaningful promise, the Vietnamese primary health care system was lauded as a model for resource-poor countries who wanted to stretch their health care resources to obtain greatest effect. Health workers in every one of the almost ten thousand communes in the country provided primary care, there were many well functioning district hospitals, and health care was provided free of charge. Even in areas of the south long neglected by the former government and devastated by the war, health care services became available and people's health improved. Annual government health expenditure per person in 1990 was just 83 US cents, lower than Nepal and Bangladesh.

The infant mortality rate in Vietnam has dropped from one hundred to fifty over the past forty years. This is about half of the rate expected for an Asian country with the same gross domestic product. UNICEF's "The Progress of Nations" report last year praised Vietnam for leading the world in the prevention of under-five deaths. Vietnam has led the "world child survival revolution" without any Western economic aid. Half of neo-natal deaths have been due to neo-natal tetanus; recent improvements in immunisation delivery to women of child-bearing age may cause the IMR to fall further.

There are several other health indicators to demonstrate that Vietnam has achieved a lot for the money it has spent. It has a measles immunisation rate of 88%, rising from just 20% ten years ago. UNICEF reports Canada's rate to be 85%. Vietnam has one fully trained doctor for every three thousand people, and a large cadre of assistant doctors and auxillary health workers. There is one in-patient bed for every three hundred people. The birth rate of thirty per thousand has been falling since mid-century and it is clear that a demographic transition is underway. Vietnam boasts a remarkable female literacy rate of 84%.

One might expect that with such excellent indicators of health status, the health of Vietnamese people would simply improve further as high economic growth rates turn one of the world's very poorest countries into the newest "East Asian Tiger". The scenario is not likely to be so simple.

As the People's Republic of China initiated market reforms, it held health and education services in the public sector until reforms were well underway. An educated and healthy population was seen as an essential prerequisite for economic reform to be successful and economic growth to take off. Vietnam has taken another direction. The government withdrew financial support for the system of health workers at the periphery, initiated user fees for health services, opened up the drug manufacturing and supply system to the market, and legalised private practice for health workers.

The results of these changes have been predictable. User rates at commune health centres dropped, as patients left public sector health services to attend private practitioners. With so many doctors and paramedical workers trained in the country, health care workers in private practice began to work almost everywhere except remote areas. Many under-paid government health workers in the periphery have abandoned their posts, leaving under-serviced areas with fewer staff than before reforms were initiated.

The pharmaceutical manufacturing and supply system is in disarray. There is in Vietnam as yet no legislation for the regulation of retail pharmacies, so untrained tradespeople act as health workers in medical shops that have sprung up in both cities and rural areas. Adulteration of pharmaceuticals is believed to be common and national essential drug policy has all but been abandoned.

User fees and insurance systems funding government health care and a vigorous private health care system should lead in time to more stability in the health care delivery system. The current turmoil and lack of direction will make it difficult for Vietnam to face several major health challenges in the years ahead.

Malaria is the number one cause of both morbidity and mortality in the country, and Vietnam is experiencing a major epidemic of this disease. Malaria has now become more prevalent

than it was at the country's reunification almost twenty years ago, after a long war period without regular malaria control. Just as suppliers of Soviet DDT for residual insecticide spraying began to run out, many nonimmune people from the overpopulated plains began to migrate into malarious hilly areas. Drug resistant falciparum malaria has increased dramatically.

Insecticide-impregnated mosquito nets are a new twist to an old technology that Vietnam has chosen as one of its strategies for malaria control. Nets may also decrease the incidence of two other common diseases, dengue and arbovirus encephalitis. Worldwide efforts to eradicate malaria have failed, so an effective system of rapid treatment for malaria cases is also needed. The health care delivery system in the hills of north and central Vietnam will need more financial and managerial support if malaria is once more to be controlled.

Diarrheal diseases still cause much morbidity and even mortality in a country where primary health care is reported to be successful. Rural people in Vietnam have their own vernacular terms for the syndromes induced by the common conditions of shigellosis and amebiasis. Only half of city dwellers and a third of people who live in rural areas have access to safe drinking water. The national diarrheal disease control programme has just received an excellent evaluation by the World Health Organisation; it is being expanded. For further control of diarrheal diseases a major investment in clean drinking water supply and rural sanitation will have to be made. Financial resources for these programmes must be raised by the Vietnamese revenue collection system which requires a major overhaul itself.

Vietnam's wartime emphasis on regional food self reliance has led to both military victory and a situation where some areas have food surpluses and other areas food deficits. Although Vietnam is a leading rice exporter, almost half of the country's children under five are under-nourished. Iodine deficiency is common in the highlands, and there are areas with major problems of vitamin A and iron deficiency. This situation invites comparisons to other Asian countries with chronic national food deficits and high degrees of social inequity.

The solutions to the problem of under-nutrition are not simple. The country has set itself a goal of eliminating vitamin A deficiency and iodine deficiency by 1995. Periodic vitamin A supplement is being tacked on to episodic National Immunisation Day programmes and plans have been made for universal salt iodisation. Vietnam's transportation system needs extensive renovation before it can be used to move rice efficiently between food surplus and food deficit areas. Finding effective ways to reduce under-nutrition in a situation of extreme resource limitation provides economic planners and nutritionists with many challenges but relying on the market economy to improve the situation may simply allow it to become worse.

Tuberculosis is near the top of the list of causes of mortality nationwide. The incidence of this disease will probably increase dramatically when AIDS begins to make its presence felt. Fewer than two thousand people in Vietnam have tested HIV positive so far, but Vietnam has the same explosive combination of factors that has led to a decimating epidemic in neighbouring Thailand. With urban injected drug use, ulcerating sexually transmitted diseases, and an active sexual service industry, it is only a matter of a few years before Vietnam's heterosexual HIV epidemic begins to have an economic impact.

Vietnam's population growth rate is currently 2%. The national family planning programme has for many years depended almost solely on intrauterine devices and early abortion. About half of women of reproductive age use one of these methods. Condoms and oral contraceptives are just becoming available in parts of the country; barrier methods are especially needed as HIV begins to spread. Simply supplying contraceptives to increase the range of contraceptive choices and meet the current unmet needs will require massive doses of capital for Vietnam's family planning programme. The United Nations Family Planning Association will not be able to keep up supply and the market is not yet ready to take over.

The people of Vietnam have faced many challenges in their long history. In the last few years of the millenium they have a few new ones to face before they achieve Health for All. After years of isolation, they deserve Western support in their struggle to improve their health.▼

Jamie Uhrig
Hanoi
January 1994

Jamie Uhrig is a member of the Medical Reform Group working in Hanoi.

NEWS BRIEFS

OHIP curbs

Ontario's NDP government has acted to exclude temporary residents from OHIP coverage. Among those who are no longer covered are about 22,000 foreign workers and their families living in Ontario, and about 19,000 international students. New residents will be subject to a three-month wait before coverage begins, and Ontario residents who have been out of the province for more than 183 days will also have to wait before coverage resumes unless they made prior arrangements with OHIP. People arriving in Ontario who don't plan to live in the province permanently are no longer to be covered. The province is also continuing to press the federal government to pay the health care costs of refugee claimants, but has agreed to reinstate the coverage of refugee claimants whose time-dated health cards expired July 1. Ontario becomes the sixth province to adopt similar measures. Critics have questioned the legality of some of the measures, as well as the practical difficulties of enforcing them. Howard Greenberg, chairman of the immigration section of the Canadian Bar Association, said that he objects to the changes because the workers involved pay taxes in Canada. The Ministry subsequently announced that pregnant women who arrived in Canada before April 1 would be exempted from the policy.

April 2, 1994

Workers compensation reforms

Reforms to the Workers' Compensation Board remain controversial with both labour and employer organizations. The reforms were agreed to by a special labour-management committee created by Ontario Premier Bob Rae to sort out the WCB's problems. The changes, which are supposed to reduce the Board's long-term deficit, were supported by Gord Wilson, head of the Ontario Federation of Labour, a member of the committee, and by Ontario Labour Minister Bob Mackenzie, as well as by employer representatives on the committee.

The effect of the reforms, according to the committee members, would be that injured workers will lose money to inflation, but will gain a better chance of returning to their jobs. Under the formula that is at the heart of the changes, workers' benefit gains would lag 25 per cent behind the cost of living, and in addition would be docked 1 percentage point of the inflation rate. Stopping the full indexing of benefits was a key goal of employers in the negotiations.

Wilson said that workers gain because the agreement contains a strong commitment to rehiring injured workers. The fully disabled and some workers with the lowest pension incomes are to keep their indexed benefits. The WCB provides about $2.4 billion in benefits and services to more than 200,000 injured people yearly.

Some business leaders were critical of the provisions requiring employers to take back injured workers.

Buzz Hargrove of the Canadian Auto Workers Union criticized the accord's rewriting of the WCB's purpose. "They're shifting the emphasis away from a program to benefit workers and they're emphasizing the financial end of it," he said.

Injured workers' organizations were critical of both the terms of the agreement and the process used to arrive at it. "I don't want somebody else speaking for me. I want a representative of mine at the table," said Don Comi, head of the Niagara District Injured Workers' Organization. "We want to be part of the process".

Mandatory reviews

Alberta doctors will become the first in Canada to undergo regular mandatory evaluations. "It seems pretty clear we're being too reactive instead of being proactive in terms of stopping potential problems," said Larry Ohlhauser, registrar of the Alberta College of Physicians and Surgeons. "The goal here is to fix things before there's a complaint... There's no point looking at a pilot's performance after a crash." The College has yet to determine how it will conduct the evaluations, which each physician will undergo every seven to 10 years. Evaluations will not begin until 1996 at the earliest. Other provinces such as Ontario conduct random peer reviews. Ontario evaluates about 400 doctors each year.

April 6, 1994

Cancer strategy announced

The Ontario Ministry of Health has announced a cancer strategy to combat waiting lists for treatment and to establish plans for cancer prevention. The cancer strategy, called *Life to Gain*, includes provisions for an additional $8 million for 100 more bone marrow transplants each year, which is expected to eliminate the existing backlog. Additional operating funds will be made available to regional cancer centres to operate radiation equipment. A task force to recommend "appropriate

next steps" for cancer prevention is to be set up. A provincial cancer network which will include health care providers, hospitals, agencies, community groups, and patients, is being set up to link services. Ontario Cancer Treatment and Research Foundation president Dr. Charles Hollenberg said he was "very pleased" with the new strategy, calling it "very imaginative and very badly needed."

April 9, 1994

Law could free criminally insane

An Ontario court is being asked to force Ottawa to proclaim a law that would limit the length of time a person can be held in a psychiatric hospital after being found not guilty of a crime because of mental illness. If successful, the constitutional challenge could lead to the release of mental patients who have spent more time in hospital than the maximum sentence for the crimes they were accused of. Advocates for the mentally ill say the law is long overdue, calling the current system of indeterminate incarceration discriminatory. However, Peter Insley, a lawyer representing the British Columbia government, which has been asking the federal government not to proclaim the law, said that "whether a mentally disordered accused should be on the streets boils down to a medical decision. To adopt a legal model undermines that." The case is being brought on behalf of Denis LePage, who has been in the Oak Ridge facility for the criminally insane since 1977.

April 11, 1994

Out-of-country coverage cut

The Ontario government has reduced its coverage of out-of-country hospital stays from $400 a day to $100 a day, saying it needs to save the money. The $400 figure was based on the estimated cost of a one-day stay in an Ontario hospital. "I think that anybody would be very foolish to leave Canada without health insurance," said Ontario Health Minister Ruth Grier in announcing the move. Ontario's action, which violates the Canada Health Act, is being challenged in court by a "snowbird" group, and federal health minister Diane Marleau has said she will takes steps to enforce the Act. Grier said the reduced coverage is in line with coverage provided by Alberta and Saskatchewan, and higher than B.C.'s $75 a day. She said that 140,000 Ontarians received out-of-country hospital care last year. Eric Izzard of the Canadian Snowbird Association said that "The Canada Health Act has a portability clause that says a province must pay the same for health care outside of Canada as they do inside Canada.... "Right now, we feel betrayed by the NDP government."

April, 1994

Pay at the door

A report by the *Toronto Star* indicates that some Toronto hospitals are increasingly asking patients for cash up front. In several hospitals, patients arriving without a health card are asked to pay $25 on the spot — the payment being refundable if you show your card to hospital officials within 24 hours. Patients arriving by ambulance are hit with an immediate $45 charge rather than being mailed a bill. Non-residents are also being charged a hefty up front fee for the emergency room. Hospitals charging the fees included Toronto East General, North York General, and Scarborough Centenary. Debra Bloomfield, spokeswoman for North York General, said "This is not a revenue-generating thing. We don't even like to process the $25. What we really want is the health card number." East General's controller, Al Kramer, said that each year, about $70,000 worth of admission, emergency and ambulance services at East General are never paid by patients, which means the hospital has to absorb the loss. Non-residents at East General now have to pay a flat $200 fee for the emergency room, which doesn't include doctors' fees, diagnostic tests or anything else associated with the visit. Scarborough Grace charges out-of-country patients $110 up front for an emergency room visit; North York General asks $225.

April 13, 1994

Marleau to enforce Canada Health Act

Federal Health Minister Diane Marleau has cut British Columbia's federal transfer payments because the B.C. government is allowing a groups of doctors in the province to extra-bill, and is looking at similarly penalizing Alberta and Ontario for violations of the Canada Health Act. Extra billing is not allowed under the provisions of the Canada Health Act. Marleau said that B.C.'s transfer payments are being cut by an amount equal to the extra-billing taking place. She is also pressing the Alberta government to account for violations of the Canada Health Act taking place in that province. Alberta has private eye clinics which charge large "facility fees" of

$1,000 or more cataract surgery, and has allowed the establishment of private MRI clinics.

"Services have to be given to people based on need, and not on the size of their pocket-books," Marleau said. "I am adamant there will be no extra-billing."

Ironically, however, Ms Marleau's get-tough approach is being rapidly undermined by her government's failure to reverse cutbacks in federal transfer payments brought in by the previous Progressive Conservative government. The result of these cutbacks will be to eliminate all federal transfer payments for health care within a few years, thereby removing the federal government's enforcement mechanism to ensure adherence to the Canada Health Act.

April 23, 1994

HIV tests for immigrants

Immigration Minister Sergio Marchi says that the government is considering whether to test all potential immigrants for HIV and then deny entry to those who have the virus. At present, people with serious medical conditions like cancer or advanced AIDS may be denied entry to Canada on the grounds that their condition would put a burden on the health-care system.

April 26, 1994

Manning defends extra-billing, user fees

Reform Party Leader Preston Manning has said that he supports the right of provinces to establish private clinics without interference from the federal government. He said provinces should have more flexibility to raise money from private sources. "There is a two-tier system already, not just in Alberta but all across the country. People with money are going to these high-powered clinics in the United States. We're losing them anyway. We're saying, 'improve it, by allowing them to do it in Canada instead of somewhere else.'"

April 28, 1994

Drug legislation at issue

Generic drug companies are pressing the federal Liberal government to make good on its promises to reverse or amend the drug patent legislation (Bill C-91) passed by the former Progressive Conservative government in 1992. The generic industry is engaged in a media and lobbying campaign to show that the legislation is costing Canadians hundreds of millions of dollars in additional drug costs.

Among the provisions they particularly want revoked is one that made the terms of the legislation retroactive to December 1991, two years before it came into effect. That provision alone cost consumers and provincial governments as much as $2 billion, according to the Canadian Drug Manufacturers Association.

Industry Minister John Manley says that the government is looking at the effects of the legislation on prices, and to see if the industry has lived up to its investment promises.

For their part, the multi-national brand-name drug manufacturers are once again threatening to pull investment out of Canada if the legislation is changed. However, the new investment promised at the time the legislation was being discussed is proving to be less than a sure thing. In April, Eli Lilly Canada Inc. said it would not be proceeding with the $170 million expansion it announced when Bill C-91 was being passed. John Pye of the Pharmaceutical Manufacturers Association of Canada, which speaks for the brand-name multinationals, said that "forces in the marketplace" are responsible for the fact that the promised investments are not materializing.

Bloc Quebecois House Leader Michel Gauthier condemned the Liberal government for even discussing the legislation. He said that just the suggestion of a review of the legislation has caused some companies to put investment plans on hold.

April 28, 1994

Safety inspections called inadequate

A decline in enforcement of workplace safety by the Ontario government is resulting in more injuries and deaths, a union leader has charged. Fred Upshaw, president of the Ontario Public Service Employees Union, says that by significantly reducing the number of inspectors and the number of inspections, the NDP government "comes close to giving employers a license to kill". Government safety inspection staff have been reduced by 25 per cent since 1989, and the number of inspections in the same period has dropped by 40 per cent. The number of directives against employers and stop work orders has dropped significantly, and financial penalties against employers and supervisors declined 69 and 33 per cent respectively. Two figures showed an increase: the number of fines against workers jumped more than 400 per cent over the last four years, while the number of workers killed on the job rose from 232 in 1992 to 292 in 1993.

NEWS BRIEFS

Business leaders immediately lashed out at Upshaw, saying his comments were "irresponsible" and didn't make sense since it is in the interests of companies to reduce job accidents. "I'm offended," said Ian Howcroft of the Canadian Manufacturers' Association.

April 29, 1994

Benefits ruling reversed

Ontario's Divisional court has overturned a decision and ruled that the Ontario Blue Cross does not have to provide family benefits to the lesbian partner of a Toronto nurse. A human rights board of inquiry had ruled last year that Blue Cross had to offer the benefits.

May 3, 1994

Photo ID cards coming

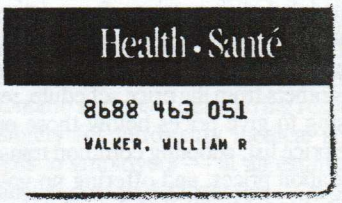
Ontario's Ministry of Health is introducing new OHIP cards that will bear the card-holder's photograph, signature, birth date, sex, name, and address. A magnetic strip will carry the same information in machine-readable form. The new cards are intended to help prevent fraud and misuse. Health Minister Ruth Grier said that the cost of the new cards will be $30 million annually for three years, and then $19 million a year.

May 4, 1994

Payroll tax cut

The Ontario government gave companies a break on employer health taxes in its spring budget. Employers will not have to pay an increase in the health tax if wages are raised or workers added. Instead, a company's tax will be limited to last year's total. The saving will amount to about $600 for a worker being paid $30,000. Finance Ministry officials estimate that the tax break will be worth about $200 million a year, and express hope that the money will be used to create new jobs.

May 6, 1994



This card is full of holes.

ONTARIO BLUE CROSS

Private firms eye medicare gaps

The move by governments across the country to cut back on publicly financed health care is leading private insurance companies to move back into the field of providing health care coverage. Blue Cross launched its campaign in May with full-page ads showing a picture of an Ontario health card with a caption below it reading "This card is full of holes." The ads suggest that costs not covered by OHIP can amount to thousands of dollars a year.

Ontario Health Minister Ruth Grier said she welcomed the Blue Cross campaign. "I welcome this debate. It's important for people to have all the information about how much health care should be paid for by taxes and how much paid for by individuals."

"There's a buzz out there. There's a lot more interest," said Robin Ingle, president of John Ingle Insurance, in announcing that his company will be offering a comprehensive plan to Canadians providing extended health-care benefits not covered by medicare. "As the gap widens between what the government pays for and what the patient pays for, there's more room for private insurers, and we want to be there with a product. This will be our first such package in 30 years." Mr. Ingle said he believes Canada is headed for a two-tier health-care system, and that he has noticed more and more physicians offering services not covered by medicare. "I've never seen so many entrepreneurial doctors in Ontario before," Mr. Ingle said. "They're opening rehabilitation clinics... providing special cosmetic surgery and other specialized treatments, even penis-lengthening. And they've got people willing to pay."

May 7, 1994

Poor dying younger

Life expectancy for some groups in Britain has worsened for the first time in 50 years, research published in the British Medical Journal shows. The study says there is clear evidence that poverty rather than personal behaviour is the greatest risk to health. The study shows that mortality rates in the most deprived areas of the North are now as bad for some age groups as in the 1940s, and are four times higher than in the most affluent areas. In the poorest areas, mortality rates have risen in absolute terms in men under 45 and women aged 65 to 75, reversing previous improvements.

May 8, 1994

Nova Scotia restructures

Nova Scotia's Health Minister Ronald Stewart has announced a restructuring

of the province's health care system. Three hospitals will be closed and services will be cut at 29 others. Some hospitals will lose departments and have to close beds, while others will be converted into community health centres. Hospital workers, like other public sector workers, are being hit with a three per cent rollback in wages and a suspension of collective bargaining.

May 13, 1994

Nurses win racism case

Toronto's Northwestern General Hospital has agreed to pay seven nurses a total of $320,000 and overhaul its management practices to ensure the institution is free of racism, in a settlement reached with the Ontario Human Rights Commission after nurses alleged that assignments, disciplinary actions and promotions were based on racial factors, with white nurses receiving preferential treatment. The hospital did not admit guilt or issue an apology, but agreed to pay the settlement, establish an internal human-rights committee, and give race relations training to its nearly 1,000 staff and volunteers.

May 13, 1994

Hospitals suing gas firms

Hospitals in Ontario and British Columbia are suing five foreign-owned gas firms which were convicted of conspiring to rig prices for compressed gases in Canada. The five companies, Union Carbide Canada Ltd., Air Products Canada Ltd., Liquid Carbonic Inc., Canadian Oxygen Ltd. and Canadian Liquid Air Ltd., paid fines totalling $6 million after they were convicted. Federal competition branch investigators found evidence that the compressed-gas conspiracy existed as far back as 1954, but after plea-bargaining, the companies each pleaded guilty to operating it for one year. The companies admitted to conspiring to adopt a common price schedule; raising prices for existing customers to the agreed-upon level; always quoting prices for prospective customers from the price schedule; refusing to give prices below those on the price list; adopting common transportation prices, and offering no volume discounts. 53 B.C. hospitals and eleven Ontario hospitals have so far launched damages suits against the companies. An industry analyst quoted in the *Globe and Mail* estimated that the over-charging amounted to $80 million a year across Canada.

May 14, 1994

Drug tab triples

The cost of prescription drugs used by Ontario seniors more than tripled between 1985 and 1993, according to a report, *Patterns of Health Care in Ontario*, released by the Ministry of Health. Prescription costs for seniors paid for the province's Ontario Drug Benefit Plan (ODBP) rose from $212 million in 1985-86 to $646 in 1992-93. Among the factors responsible for the increase were increased drug use, increased prices, and the replacement of older drugs by newer more expensive medications. Drugs not available in 1985 accounted for almost two-thirds of total expenditures in 1992-93. According to the author of the report's chapter on drug use, Geoffrey Anderson, some of the new drugs, especially those used for cardiovascular conditions, may be less effective and more expensive than those they replaced. "There's some real breakthroughs but there is also a push to use more expensive medications," Anderson said. The report covers prescriptions but not drugs administered in acute-care hospitals. The ODBP now accounts for about six per cent of Ontario's health-care budget, double the share 10 years ago. Other provinces have seen similar increases in the costs of their drug plans. Saskatchewan, the only province whose plan covers its entire population, recently introduced graduated user fees.

MRG member Dr. Joel Lexchin said that "asking people to pay more or just not covering their drugs any more are pretty crude methods." "Rather, governments should put their resources into rational prescribing habits. There has to be some mechanism to do this. Newer drugs should only be used when they have clear, demonstrated benefits, and not because they're new."

May 26, 1994

Air ambulance reforms recommended

A panel reviewing Ontario's air ambulance system has said that the system is basically safe, but recommended changes in the way air ambulances are dispatched, in the training and deployment of attendants, and in the availability of aircraft for emergency flights. The panel found that the way paramedics are recruited and trained has led to chronic staff shortages.

May 27, 1994

Unemployment drives health costs

Stress-related illnesses suffered by Canada's unemployed cost the gov-

ernment $1 billion in extra health-care costs last year, according to a study by Dr. Chandrakant Shah of the University of Toronto's preventive medicine and biostatistics department. Shah, who presented his paper at a meeting of the Ontario Medical Association, said that the unemployed are more likely than those with jobs to suffer from heart disease, hypertension, suicidal tendencies, depression, insomnia and other problems. Increased health-care costs come from increases in prescription drugs, such as tranquillizers, hospital visits and trips to the doctor's office, he said. Spouses of unemployed people often have similar health problems and children may show their distress through behavioural problems like hyperactivity or depression, said Shah.

May 28, 1994

Ambulance system said mismanaged

Toronto ambulance workers say that poor management, budget cutbacks, and the effects of the province's social contract are creating serious problems in the ambulance system. Appearing before a Metro Toronto committee, the workers said that response times are increasing and that staff shortages are resulting in attendants and paramedics being required to work longer hours, leading to physical and emotional burnout. Ambulance commissioner John Dean acknowledged that his department is "getting close to crisis" and that many of the workers' complaints are justified. "We have less staff to do the job. We have less cars on the road," he said. But Dean insisted that the system still works and that the public is not in jeopardy.

June 1, 1994

Third-party billing criticized

The Ontario government's decision to require those who request third-party services that are not medically necessary — specifically sick notes for absences from work — to pay for them is being criticized by both employers and union leaders. The Human Resources Professionals Association of Ontario says that "transferring responsibility for third-party medical services to employers — at an estimated annual cost of $75 million — would seriously impair the ability of Ontario business to regain its prerecession vitality and create jobs." The association says that if employers are required to pay, they will want the right to choose their employees' doctors and to received a detailed report from the physicians so they will know that an employee's absence is justified. "Physicians who issue certificates paid for by employers should be required, when requested by employers, to provide more detailed information, and employees should be deemed to consent to release of such information." Labour leaders say that employees now often end up paying for sick notes demanded by their employers. Julie Davis, secretary-treasurer of the Ontario Federation of Labour, said that many employers routinely demand sick notes after three-day absences, forcing employees suffering from colds or flu to make unnecessary visits to the doctor, and then to pay for them.

June 8, 1994

Controversy over incorporation

The NDP government's promise, made at the time of its social contract agreement with the Ontario Medical Association, that it will introduce legislation to allow doctors to incorporate is coming under attack from a number of directions. The Health Professions Regulatory Advisory Council has released a report strongly opposing incorporation. The report concludes that incorporation of any regulated health profession is not demonstrably in the public interest, and is in fact potentially contrary to the public interest on a number of grounds. The OMA is insisting that a deal is a deal and that the government is obligated to proceed. Financial analyses have suggested that physicians earning more than $200,000 are the ones who will benefit from the tax breaks associated with incorporation, and that the province stands to lose upwards of $80 million a year in lost income tax revenue. The figure would be likely to increase rapidly since the government would be forced to extend the same privilege to other professionals such as dentists. At present, doctors in Alberta and British Columbia are allowed to incorporate. The Medical Reform Group issued a statement opposing incorporation.

June 16, 1994

AIDS reporting contentious

Physicians who treat AIDS patients have said they will not comply with a controversial new policy of the College of Physicians and Surgeons of Ontario which requires them to report physicians infected with the HIV virus. Under the new policy, doctors treating physicians infected with HIV or Hepatitis B must provide a report to the College, stating whether the infected physician's medical practice should be modified. According to the College's director of policy, Janet Ecker, the College council formed the

policy because it feels it needs to "assess whether action needs to be taken to protect the public." Dr. Philip Berger, an MRG member who is on the executive of the Toronto HIV Primary Care Physicians group, said "I won't comply; this is totally unjustifiable." According to Dr. Berger, there have been no documented cases of a physician transmitting HIV to a patient. "They've singled out HIV alone for this type of monitoring," he said. "We don't have to report doctors who have seizure problems, diabetes, untreated mental illness. All of those things can fiercely impinge on how a physician practises medicine, yet none of them have to be reported." Dr. Berger said that "it will drive physicians who may be at risk for HIV underground." Physicians who discover that they have the AIDS virus will forgo treatment, he said. Dr. Berger also noted that nurses and other health care professionals are not subjected to this policy.

June 17, 1994

Consent Act called flawed

The College of Physicians and Surgeons of Ontario is calling on the provincial government to amend certain provisions of the new Consent to Treatment Act which require a "rights adviser" to be called in whenever a patient is deemed incapable of consenting to treatment. College registrar Dr. Michael Dixon said that, while the College supports the principle of the act, its legislative flaws will work against patients. The College wants the act amended so physicians can immediately seek the consent of a family member or substitute decision maker if the patient is incapacitated and the patient doesn't object. As presently drafted, the legislation requires that a rights adviser must be called in first. The College says that it doubts that rights advisers will be available around the clock in hospitals, nursing homes, and clinics, and suggests that the legislation will result in a cumbersome expensive bureaucracy and lengthy delays in treatment.

June 20, 1994

TB on rise in Eastern Europe

After nearly forty years of steady decline, the death toll from tuberculosis is increasing dramatically in most countries of the former Communist bloc. The World Health Organization warns of an impending epidemic, estimating that more than two million Eastern Europeans were infected with TB bacteria in the past five years, and that 29,000 people died from TB last year in Eastern Europe and the former Soviet Union. In Moscow, the incidence of TB has almost doubled in the last two years alone. "This is clear evidence of the failure of TB control programs, which is a real tragedy because TB is so curable," said Kathryn Wilkins, a senior analyst with Statistics Canada who has been monitoring international TB developments.

June 22, 1994

Hospital plans to bill patients for beds

Toronto East General and Orthopaedic Hospital says it intends to begin charging patients who are occupying acute care beds while they wait for a space to open up in a nursing home or a chronic care facility. Patients who don't belong in an acute-care hospital will have to pay $149 a day after they have been in the hospital 21 days. After 29 days, the rate goes to $298 a day, and after 37 days the rate will go to $447, according to hospital spokesperson Sheila McEachen. The hospital says the charges are necessary because the provincial funding formula does not cover the costs of patients' stays. "We have been trying to work with the Ministry of Health on this issue for over a year," hospital president Gail Paech said. "The ministry's response has been silence." Because the government has allowed long-term facilities to increase the number of semi-private and private beds, those who can't afford them end up staying in hospital until a funded bed opens up, Paech said.

The Ministry of Health has told the hospital that its planned course of action is illegal.

There was outrage among those who would be affected by the proposed policy. "It could take up to six months to get my 85-year-old mother into a nursing home," said Heikki Nihtila, whose mother Marta recently had her right hip replaced at the hospital. "We'll refuse to pay the bill. What are they going to do? Throw her in jail? Make her do community work?"

The hospital subsequently issued a statement saying that the policy would be applied to elderly patients who refuse to go to a nursing home that has accepted them. "As soon as someone refuses, the charges go into effect," Paech said.

June 22, 1994

Drug stores fight tobacco ban

Ontario drug store owners are planning to take the province to court to overturn a new law which would bar them from selling tobacco. The legislation introduced by the NDP government would make it illegal to sell

cigarettes to anyone under 19, or to sell them in drug stores or in vending machines, as of December 31, 1994. Health Minister Ruth Grier said that her Ministry is banning tobacco from all health-care facilities. Drug stores are considered to be health care facilities because they earn 40 per cent of their profits from the Ontario Drug Benefit Plan, Grier said.

Larry Rosen, co-owner of five drug stores, said that "we feel the provincial government doesn't have the right to criminalize the sale of a legal good in only one portion of the retail sector". He said that the bill is discriminatory because 120,000 other outlets will continue to sell tobacco. Rosen said tobacco sales account for 10 to 15 per cent of drug stores' overall sales, but without cigarettes, spinoff sales will also be lost. He said sales losses could force 140 pharmacies to close and layoffs at many more. About half on Ontario's 2,500 drug stores sell tobacco. An estimated 23 per cent of tobacco sold in the country is distributed through drug stores.

"Here we have pharmacists going to court to protect the right to sell the Number 1 cause of disease and death in this country. We think this is nothing short of pathetic," said Michael Perly of the Campaign for Action on Tobacco. Gar Mahood of the Non-Smokers' Rights Association argued the challenge is essentially driven by Shoppers Drug Mart, a subsidiary of Imasco Ltd., a major tobacco manufacturer.

June 22, 1994

Money for community care

The Ontario government has announced that it is diverting $29 million from institutional care for people with developmental disabilities to community care and local support services. At present, the government operates nine institutions for the developmentally disabled, serving 2,571 people at a cost of $286 million. 30,000 people with developmental disabilities and their families use government-funded services provided by more than 380 non-profit agencies, at a cost to the government of $609 million. "This is not going to solve the problem, but it will help," said Ken Haggerty, director of an advocacy agency for the developmentally disabled. "The most significant part of the announcement is that money saved from the shutdown of institutions will stay in the sector."

June 22, 1994

Call for assisted suicides

The AIDS Committee of Toronto (ACT) is calling on the federal government to amend the Criminal Code to allow for assisted suicides. ACT board member Alan Stewart said that only a small proportion of the AIDS sufferers he has known choose suicide, but the availability of the option provides solace that they can end the pain and indignity if it gets too severe.

July 6, 1994

Hospital cuts called haphazard

Cuts to hospital operating budgets have been haphazard and have resulted in longer waiting lists, elderly people being stuck in acute care beds while waiting for chronic care beds to become available, and families being burdened with sick parents at home, according to a review by the Metropolitan Toronto District Health Council, which reviewed the operating plans of 43 hospitals. The review said that many administrators did well at making cuts to their institutions, but since no one was co-ordinating the cuts over-all, hospital administrators unwittingly left gaps in services, often affecting the most vulnerable. According to Lorne Zon, executive director of the Council, the result has been growing waiting lists for those seeking help in mental health and addiction services; major problems with access to radiotherapy, chemotherapy, palliative care for the dying and bone marrow transplants; insufficient paediatric and adolescent services; and extensive waiting lists for dialysis. Patients are being discharged from hospital sooner, leaving parents looking after sick parents and children in their own homes. A growing number of elderly patients are being housed in acute care hospitals while waiting for spots in chronic care facilities.

July 7, 1994

Morgentaler in court again

Dr. Henry Morgentaler is going to court to challenge the New Brunswick government's ban on free-standing abortion clinics. Dr. Morgentaler performed five abortions at his new Fredericton clinic at the beginning of July in defiance of the law. The New Brunswick College of Physicians and Surgeons then restricted his license after being requested to do so by Health Minister Russ King and called a board of inquiry to determine whether Dr. Morgentaler committed professional misconduct. Under New Brunswick law, abortions are permitted only in three accredited hospitals and only with the approval of two physicians. "I blame the government for this absolutely useless fight and

waste of taxpayers' money", Morgentaler said.

July 14, 1994

Plain packaging

Tobacco companies are mounting a vigorous campaign to derail proposed plain packaging regulations. Federal Health Minister Diane Marleau announced in April that she planned to introduce legislation requiring plain packaging for cigarettes. The move was seen by anti-smoking activists as an attempt by the Liberal government to regain some of the credibility it lost with public health groups after it lowered cigarette taxes earlier this year. They caution, however, that Marleau will need to line up other cabinet members behind her initiative if legislation is to be introduced.

Tobacco industry executives like Michel Descoteaux of Imperial Tobacco Ltd. insist that plain packaging is a futile measure that "will have no impact on our sales", but are simultaneously lobbying furiously to stop the plan dead in its tracks. The industry argues that a plain-packaging law would violate "corporate freedom of speech" and would amount to a state-sponsored seizure of a company's trademark.

Proponents of the legislation say that such a law would be a reasonable limit on tobacco companies, given that an estimated 40,000 people in Canada die prematurely each year from illnesses caused by tobacco.

MEETINGS AND CONFERENCES

Independent Living

The Canadian Independent Living Movement is holding a national conference in Winnipeg from **August 24 - 27** on the theme "Progress Through Partnerships: The 1994 National Independent Living Conference". The conference is billed as an occasion at which delegates will discuss past accomplishments of the "Independent Living philosophy" and determine the best route for its future development. Contact Canadian Association of Independent Living Centres, 350 Sparks Street, #1004, Ottawa, Ontario K1R 7S8, (613)563-2581, Fax: (613)563-2580.

Healthy Aging

One Voice, the Canadian Seniors Network, is sponsoring a national conference on protecting and improving Canada's health care system, **September 8 - 10**, in Montreal. Titled "Healthy Aging: A Canadian Commitment?", the conference is billed an "an opportunity for seniors to come together with researchers, policy makers and health professionals to develop innovative, workable solutions for today and tomorrow". Contact One Voice, 1005 - 350 Sparks Street, Ottawa, Ontario K1R 7S8, (613)238-7624.

MRG Fall General Meeting

The Medical Reform Group's fall general meeting has been scheduled for Thursday **September 29**.

It's Never OK

The Canadian Health Alliance to Stop Therapist Exploitation Now (CHASTEN) is holding a conference on sexual exploitation by health professionals, psychotherapists and clergy on **October 13 - 15** in Toronto. Contact Temi Firsten, c/o CHASTEN, P.O. Box 73516, 509 St. Clair Avenue West, Toronto M6C 4A7, (416) 656-5650.

Palliative Care Conference

Caritas Health Group is holding its sixth annual Palliative Care Conference on **October 24 - 25**, in Edmonton. The four key speakers will be Margaret Somerville, Director of the McGill Centre for Medicine, Ethics and Law; Josephine Flaherty, Principal Nursing Officer of Health and Welfare Canada; Ronna Jevne, of the Department of Educational Psychology of the University of Alberta, and Eduardo Bruera, Director of the Palliative Care Program at Edmonton General Hospital. For more information contact Linda Aubrey, (403) 930-5852, fax: (403) 930-5970.

Mental Health Ministry

A workshop on the theme "Mental Health Ministry in Your Neighbourhood" will be conducted at Whitby Psychiatric Hospital on **November 1**. The workshop will be a celebration of the forty-fifth anniversary of full-time hospital-employed mental health chaplaincy in Canada. The main resource person will be Rabbi Jeffrey Cohen, Director of the Division of Pastoral Resources, Department of Mental Health for the State of Missouri. There will be an opportunity to network with other people who are concerned about institutional chaplaincy and community based mental health ministry. Contact Pastoral Care, Box 613, Whitby, Ontario L1N

5S9, (416)364-4526 or (905)430-4026, fax: (905)430-4032.

Caring for a Nation

Caring for a Nation is a film project being developed by Erudite Cultural Products. The film is described as an important tool in the battle for a decent and equitable system for health in Canada. The documentary would critically examine the delivery of health care in Canada and the United States as seen by two community health clinic doctors, one in Ottawa and the other in San Francisco. Filmmaker Linda Gouriluk is looking for support for the project, in the form of endorsements, distribution of publicity, and financial support. For more information contact Erudite Cultural Products, Box 3997, Station C, Ottawa K1Y 4P2, (613)722-8512.

PUBLICATIONS

Poverty certain indicator of high mortality risk

Researchers at Simon Fraser University found a significant correlation between poverty and mortality. This association is independent of race.

The authors gathered U.S. government mortality data for about 18,000 individuals of all racial origins who had died as well as about 110,000 living person. They found that, while mortality of blacks was initially higher than of whites, the figures evened out when individuals of similar income were compared.

According to the researchers, the mortality rate for people who live in poverty is about four times that of those who are above the poverty line.

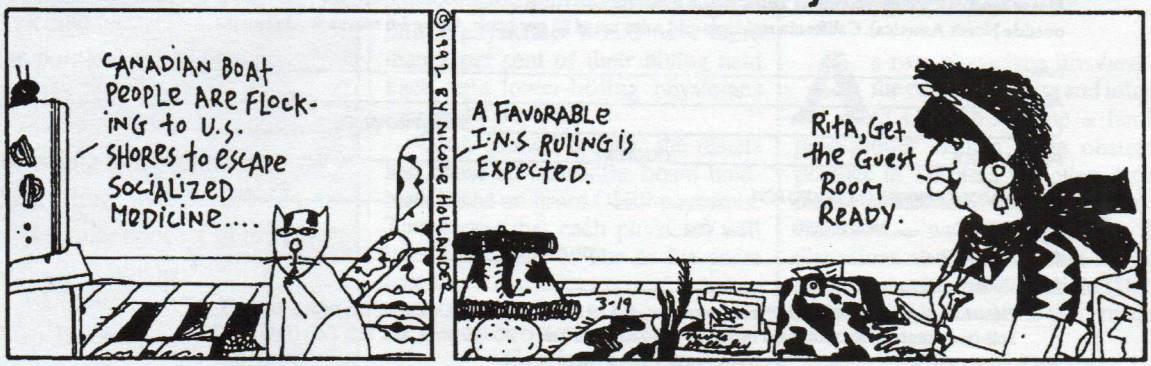
Sterling, T., Weinkam, J, Rosenbaum, W: "health may be wealth, but poverty is surely sickness." J. Natl Med. Assoc 85:906.

From the Canadian Journal of DIAGNOSIS April, 1994

User fees hyped

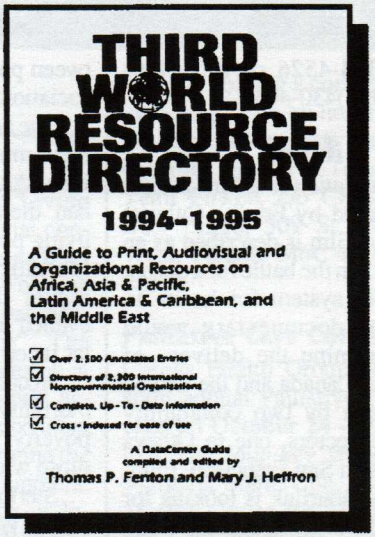
The C.D. Howe Institute has joined the ranks of those advocating neo-conservative reforms to Canada's health care system. A book of essays released by the institute, *Limits to Care: Reforming Canada's Health System in an Age of Restraint*, edited by Ake Blomqvist and David M. Brown, argues that the health care system must be reformed to improve Canada's "competitive edge" by reducing the costs of social programs. Citing suggestions that "as much as 30 to 40 per cent of health care spending goes to pay for inappropriate procedures", the book says that the fee-for-service system must be changed and that "limited" user fees should be instituted. As proponents of user fees commonly do, the book's authors argue both that user fees will reduce health care spending and that they will provide badly-needed revenue (i.e. increase health care spending). *Limits to Care* also proposes a new contractual corporate model for relationships between funding agencies (primarily government) and health service providers such as doctors and hospitals. Under a contract system, hospitals would compete for patients and referrals.

SYLVIA **by Nicole Hollander**



"...a gem in the resource world...an important and useful entry point into the Third World"
Kofi Kumado, Chairperson
HURIDOCS (Geneva)

"Succeeds in awe-inspiring fashion. . . highly recommended."
Chris Dodge, Editor, *MSRRT Newsletter*



Unique and comprehensive, the 800-page *Third World Resource Directory 1994-1995* is the premier resource for up-to-date and hard-to-find information on the peoples and nations of the so-called Third World. The directory assembles and makes accessible information and perspectives often overlooked in other reference sources: grassroots movements, human rights activists, progressive public policy analysts, and peace and social justice advocates.

Contents:

- **Annotated and cross-referenced listings** of some 2,500 books, periodicals, pamphlets, films, videos, slideshows, audio tapes, and other resources.
- **Regional and country subdivisions** for Africa, Asia, Caribbean, Latin America, Middle East, and the Pacific.
- Thirty-nine **topical divisions,** including children, development, human rights, labor, militarism, population, refugees, and women.
- A **Directory of Organizations** with full contact information for some 2,300 international publishers and distributors of Third World-related print and audiovisual resources.
- **Five detailed indexes,** by organization name, title, individuals (e.g., authors, filmmakers, etc.), geographical areas, and subjects.

Compiled and edited by
Thomas P. Fenton and Mary J. Heffron
800 pages 5 indexes 7 x 10 inches
ISBN 0-88344-941-2 ISSN 1074-3145
$64, postpaid in North America
(Calif. residents add $5/book sales tax)

Comes with commitment from Third World Resources to keep information in the *Third World Resource Directory* accurate and up-to-date. Registered buyers qualify for a computerized update of the Directory of Organizations in January 1995 (in a variety of disk formats) and hard-copy printouts of resource recommendations on particular countries and/or topics. The 1994-1995 edition of the *Third World Resource Directory* will be updated by Third World Resources and re-published in spring 1996.

ORDER FORM

Please send _____ copy/copies of ***Third World Resource Directory 1994-1995.*** $64 each, postpaid (add $2 per book outside North America). California residents add sales tax of $5 per book. Allow 4-6 weeks for delivery.

NAME _____

ADDRESS _____

CITY _____ STATE/PROVINCE _____

POSTAL CODE _____ COUNTRY _____

CHECK/MONEY ORDER ENCLOSED FOR: _____

CREDIT CARD: ___ MasterCard ___ Visa

CARD NUMBER: _____ EXP. DATE: _____

SIGNATURE: _____

Please send orders to: Third World Resources, 464 19 Street, Rm. 105, Oakland, CA 94612-2297 USA
Toll-free number for credit card orders: 1-800-735-3741. Tel: (510) 835-4692, ext. 113. Fax: (510) 835-3017.