

# 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 4 — September 1994

## Fall general meeting asks: what does "medically necessary" mean?

**T**he Medical Reform Group's fall general meeting, to be held Thursday September 29, will grapple with the concept of "medical necessity".

The idea that only "medically necessary" services should be covered under medicare has gained widespread currency. Few are willing to argue that "medically unnecessary" services should be paid for out of the public purse, but attempts to define just what "medically necessary" actually means quickly uncover diverging assumptions and agendas.

It has become obvious that governments often see this concept as a way of removing services from coverage and thus reducing their health care spending. Many physicians welcome the opportunity to provide services not covered by medicare on a user-pay basis. Progressives have argued that the definition of medical necessity is often drawn too narrowly, that dental care and prescription drugs, at least, should be seen as medically necessary.

Some have suggested that the concept of "medical necessity" can be a trap which leads us into a closed debate on "what should be cut", while the broader questions of resource allocation and the determinants of health

are ignored. Perhaps "necessary" is a yes-or-no term being inappropriately used to address questions that are fundamentally about economic and social, as well as medical, priorities.

We can be sure that this issue will be at the centre of the debate at the Liberal government's National Forum on Health Care to be held later this fall, and in subsequent debates and decisions about the future of medicare. The provisions in NAFTA which allow corporate health care providers access to uninsured health care services will guarantee additional pressures to define medical necessity narrowly.

We as the Medical Reform Group need to define our position on this issue and on the process for making decisions about priorities. What do we think should be the principles and process used in defining what should be covered by medicare?

The meeting is being held **Thursday September 29** at the Davenport-Perth Community Health Centre, 1900 Davenport Road, Toronto. The meeting starts at 7:45 pm. Dinner will be catered in, and will start at 6:30 pm. Please call 416-588-9167 if you are planning to come to the dinner so we will know how many dinners to order.

## User fees hurt sick, poor, MRG says

**N**ews reports of physician support for user fees prompted the Medical Reform Group's Steering Committee to issue a statement on August 18 reiterating the MRG's opposition to user fees. The MRG's statement as it was released to the media appears below:

Doctors who see no problem with asking patients to pull out their wallets before receiving medical treatment need to be educated about the negative effects of user fees, says the Medical Reform Group.

Delegates to the Canadian Medical Association's annual meeting voted this week to strike down a policy opposing user fees, despite warnings from some delegates that they would be seen as self-serving and greedy.

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## Medical Reform

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

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

Correspondence should be sent to Medical Reform, P.O. Box 158, Station D, Toronto M6P 3J8. Phone: (416) 588-9167 Fax: (416) 588-3765.

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

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

### 1. Health Care is a Right

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

### 2. Health is Political and Social in Nature

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

### 3. The Institutions of the Health System Must Be Changed

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

## Your membership is crucial

If you are an MRG member, you will soon be receiving a letter asking you to renew your membership for the 1994-95 year, which begins October 1.

This year's membership campaign is crucial for the future of the Medical Reform Group, because the MRG has sustained a deficit over the past two years and cannot afford to do so again.

As a letter from the Steering Committee which you received in June explained, the MRG's financial bind is attributable neither to rising expenses nor to declining membership. Membership numbers have in fact been quite stable over the past several years, while expenses have been cut by more than 10% over the past three years.

The problem is that the amount each member is paying has declined, significantly enough to put the MRG's budget into the red. Many members who used to pay a Supporting Membership contribution are now paying only the basic fee, while others are paying reduced fees in accordance with our policy that those in strained financial circumstances may pay less than the full fee.

The result has been an economic squeeze that jeopardizes the MRG's future at a time when all of our energies should be going towards promoting our agenda of progressive health care reform.

The response to the June mailing was gratifying. Twenty-nine members said they were willing to pay an additional amount to keep the MRG afloat. Several others undertook to help in publicizing the group and recruiting new members.

If you haven't already done so, we urge you to consider whether you can

afford to make a contribution to the MRG in addition to the basic membership fee.

The future of health care in Canada is the subject of intense debate. Change, for the better or the worse, is taking place and will gain momentum. User fees, two-tier health care, privatization, cutbacks, NAFTA — many of the issues which the MRG was founded to address are upon us again with a new urgency.

It is vital that our voice be heard, speaking out in favour of the MRG's perspectives and its three founding principles:

### 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.

### 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.

### The institutions of the health system must be changed

The health care system should be structured in a manner in which the equally valuable contribution 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.



## User fees hurt poor, sick

*Continued from Page 1*

The Medical Reform Group, a physicians' group which believes that health care should be available to all without financial deterrents, repudiates the stand taken by the CMA delegates.

"There is clear evidence that user fees hurt the sick and the poor," said MRG spokesperson Dr. Rosana Pellizzari.

Studies on the effects of user fees have repeatedly shown that people with low incomes are less likely to seek medical treatment for themselves or their children when user fees are charged.

When Saskatchewan instituted user fees under a previous government, physician visits by the poor and the elderly decreased by 18%, while physician visits by higher-income people actually increased. This finding is not surprising when one considers that a substantial proportion of patient visits are initiated by the physician rather than the patient.

The evidence on user fees in other jurisdictions, including the United States, is similar.

An in-depth analysis of user fees by health economists Greg Stoddart and Robert Evans, published by the Premier's Council on Health last September, demonstrated that user fees are ineffective in reducing overall health care costs, but they do hurt the sick and the poor.

"User fees should be unequivocally rejected once and for all," said Dr. Pellizzari. "Doctors who favour user fees should be clear that they are putting their own pocketbooks ahead of their patients' welfare."▼

## Getting to the Core of Comprehensiveness

Copies of *Getting to the Core of Comprehensiveness*, a discussion paper released in March 1994 by HEAL, the Health Action Lobby, will be available for members at the semi-annual MRG meeting on September 29. HEAL, a coalition composed of seven major national associations including the Canadian Nurses Association, the Canadian Medical Association, the Canadian Hospital Association, the Canadian Public Health Association and the Consumers Association of Canada, actively lobbied to protect transfer payments to the provinces during the past federal election.

*Getting to the Core of Comprehensiveness* reviews the policy context, both internal and international, for the debate on comprehensiveness. The legislation and the current problems in implementation are presented. The paper argues that what is lacking most is a "clear, coherent mechanism by which such factors [fiscal resources, society's values, demographic trends, evidence on effectiveness] can be scrutinized by all concerned stakeholders in the most objective and unobstructed manner possible".

A framework for policy making is presented: an open process where a health research group first assesses information to determine efficacy and effectiveness. The second step, the decision about what is appropriate, would be determined by a body of providers and consumers. Finally, the third step, decisions about affordability, would be completed by government.

It is HEAL's position that changes to the Canada Health Act are not necessary — the Canada Health Act is permissive in that provinces decide what providers and what level of services to fund. The fundamental change proposed is the incorporation of an open, visible decision-making process, with clearly identified areas of responsibility and accountability.

This should sound very familiar to Medical Reform Group members who have discussed resource allocation issues over the past five to six years. It is time to move our own understanding and positions forward in order to participate in the upcoming national debates.▼

**Rosana Pellizzari**

## Write! Fax! Mail!

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

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

Submissions may be faxed to (416) 588-3765, or mailed to *Medical Reform*, P.O. Box 158, Station D, Toronto, Ontario M6P 3J8, or E-mail to: [udiemer@sources.com](mailto:udiemer@sources.com)



# How should we decide where resources should go?

*Excerpts from the Medical Reform Group's policies on resource allocation, reprinted here as background for the discussion on "What does 'medically necessary' mean?"*

## Re-allocating Resources for Health: MRG Statement of Principle

*(Resolution passed May 5, 1989)*

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." (World Health Organization)

Universal access to high quality, appropriate health care is one guaran-

tee of this right, and adequate resources should be allocated to health care to protect this. However, health is political and social in nature, and it is essential that adequate resources are directed towards the eradication of social, economic, occupational and environmental causes of disease. The following principles form the basis upon which decisions should be made regarding the allocation of resources to promote and protect the highest attainable standard not just of health care, but of health status.

1) **Perspective** — Decisions regarding the allocation of health care resources and other resources in relationship to health must be viewed

broadly; i.e. within the context of how society allocates its resources in general. Since public policies unrelated to health care have major impacts on our health, health may be improved more by spending money to correct the political and economic roots of ill health — outside of the health care system — than by spending money on health care. At the same time, health care spending and the allocation of resources to promote and protect good health should be examined in relationship to total societal resource allocation, not just government spending.

2) **Equality** — all people should have equal opportunity to live in a healthy physical and social environment, as well as equal access to health care. Reducing inequalities in health status, not just access to health care, should be the highest priority in deciding how to re-allocate resources for health.

3) **Effectiveness** — Health care interventions, including organizational policies, and health protection and promotion interventions should be supported only if there is evidence that they improve the length or quality of life. The extent of the evidence that is required should be determined relative to the magnitude of the potential benefits, the risks and the costs of the intervention. Impacts on health status — i.e. well being, not just physical health — should be the primary measure of effectiveness. Because the potential to measure impacts on health status varies with the nature of the intervention, evaluations of effectiveness should be appropriate to the nature of the intervention. Both existing and new interventions should be evaluated.

4) **Efficiency** — Resources should be allocated to achieve the maximum benefits possible relative to the re-

## More traffic means less health

**P**eople who live on streets which carry heavy traffic are more likely to be ill than those on streets with only light traffic, say researchers at Lancaster University.

An investigation of over 1,000 households in ten urban areas in Scotland and the north of England showed that a range of symptoms — including headache, breathing difficulties, cough and lack of energy — were more common in residents of busy streets. The study, which was carried out by Lancaster University's Environmental Epidemiology Research Unit for the Greenpeace Environmental Trust, took account of other factors which might affect health, such as smoking, income, employment and pre-existing disease.

John Whitelegg, who headed the research and is now an environmental consultant, said that there was a direct relationship between the number of vehicles passing where someone lived

and the amount of illness they experienced. He wants to see the development of car-free, bicycle-only communities in the UK, along the lines of examples elsewhere in Europe.

"Because travel is so cheap, we use it without considering the implications," he said. "A lifestyle based on travel is not sustainable any more. Travel has to be reduced."

The study also found that people living in damp properties or homes with mould were more likely than others to report illness, though the effect of traffic was still significant after this was allowed for.

Traffic volumes are forecast to rise by between 83 per cent and 142 per cent over the next 30 years.▼

**James Munro**

*Reprinted from Health Matters, Issue 16, Winter 1993/94. Health Matters, Freepost SF 10539, P.O. Box 459, Sheffield S11 8TE, United Kingdom.*



sources expended. The viewpoints that should be taken in considering trade-offs should be those of society as a whole and the individual patient, rather than the viewpoint of those funding or providing health care.

5) **Re-allocations** — Re-allocations of resources should be directed towards the improvement of health, rather than to such things as military spending or excessive corporate profits. Decisions regarding the re-allocation of resources should be made from

a societal viewpoint, should be based on evidence of effectiveness and, most importantly, should result in an equitable as well as efficient distribution of resources.

### **Funding for Effective but Expensive Interventions**

*(Resolution passed October 14, 1989)*

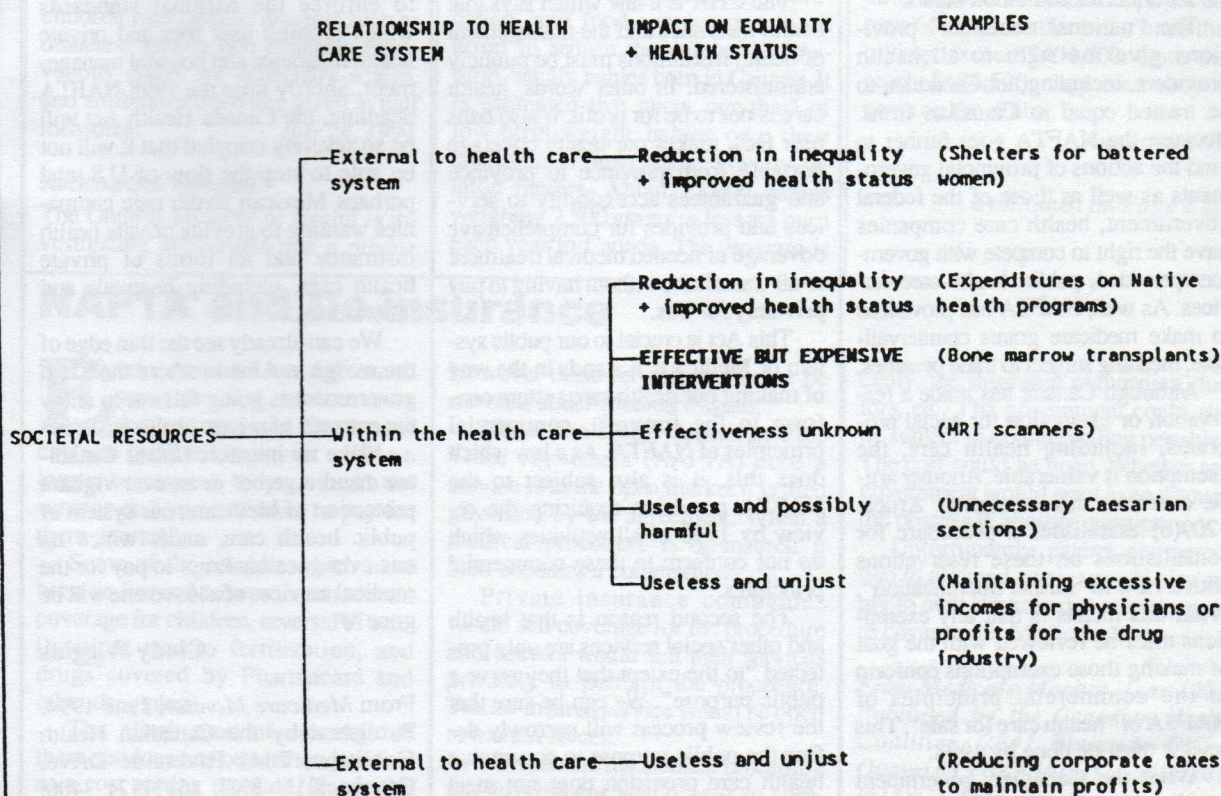
Decisions regarding the funding of effective but expensive interventions should be made in the context of the entire health budget and the total

economy. The onus is on the government to find the money by:

1) Reallocating money from within the health care system (e.g. by reducing unnecessary hysterectomies or useless pharmaceutical advertising) or,

2) Reallocating money from within the total economy (e.g. by raising corporate taxes, taxing luxury items, reducing tax shelters, or reducing military spending). ▼

## **Hierarchy of ways in which resources might be allocated**





# Health Care and NAFTA

**B**oth the original Canada-US Free Trade Agreement (FTA) and the North American Free Trade Agreement (NAFTA) which subsumed the FTA are a serious threat to the preservation of Canada's public system of health care and health insurance.

NAFTA extends coverage to all Canadian health services. Thus, they are considered "commercial services", and include nursing homes, hospitals, extended care hospitals, drug and alcohol treatment facilities, ambulance service, home care, community health clinics, medical and radiological laboratories and blood banks.

The "national treatment" provisions give the right to all health providers, including nonCanadian, to be treated equal to Canadian firms. Because the NAFTA goes further to bind the actions of provincial governments as well as those of the federal government, health care companies have the right to compete with government-provided, public, health care services. As well, NAFTA has provisions to make medicare grants countervailable, meaning subject to trade penalties.

Although Canada has made a reservation or exemption for social programs, including health care, the exemption is vulnerable. Another article overrides this exemption. Article 1209(b) establishes a procedure for consultations on these reservations with a view to "further liberalization". What this means is that any exemptions must be reviewed with the goal of making those exemptions conform to the commercial principles of NAFTA or "health care for sale". This review must be done by 1998.

What the Canadian government has done, in effect, is to make its pro-

tection for health and other social and public services transitional and has agreed that this protection should be progressively dismantled. It must be remembered that the ultimate goal of NAFTA is to "eliminate barriers to trade in goods and services and to substantially increase investment opportunities". (NAFTA objectives, Chapter One)

So what has been stopping a flood of mainly U.S. corporate health care and health insurance giants into the Canadian health care system? The first answer is the allimportant Canada Health Act.

The CHA is a law which says that health insurance and the management of health institutions must be publicly administered. In other words, health care is not to be for profit. It also bans user fees, makes our health coverage portable from province to province and guarantees accessibility to services and provides for comprehensive coverage of needed medical treatment to all Canadians without having to pay privately for this.

This Act is crucial to our public system of Medicare. It stands in the way of making our health care system conform to the forprofit, commercial principles of NAFTA. As a law which does this, it is also subject to the NAFTA provision requiring the review by 1998 of all activities which do not conform to these commercial principles.

The second reason is that health and other social services are only protected "to the extent that they serve a public purpose". We can be sure that the review process will narrowly define the public purpose to ensure that health care provision does not meet this standard. More importantly, if we

had intended to protect health care for all time from becoming a purely commercial activity, why was it not made a permanent exemption instead of leaving it to be reviewed?

Of critical importance is that all Canadians understand that the Canada Health Act is being made increasingly more vulnerable by our own federal government. Years of funding cuts and the seemingly permanent freeze on health care funding are having the effect of virtually eliminating the federal funding for health care. The cash transfers are the only mechanism which allow the federal government to enforce the national standards which prohibit user fees and private health insurance and hospital management. Shortly after the 1998 NAFTA deadline, the Canada Health Act will be so severely crippled that it will not be able to stop the flow of U.S. and perhaps Mexican health care companies wanting to provide private health insurance and all forms of private health care, including hospitals and laboratories.

We can already see the thin edge of the wedge in Alberta where the Klein government is going full out to allow the entrance of private health facilities.

Make no mistake. Unless Canadians band together in an ever vigilant protection of Medicare, our system of public health care, under which no one ever goes bankrupt to pay for the medical services of a loved one will be gone.▼

**Cindy Wiggins**

From *Medicare Monitor*, June 1994.  
Published by the Canadian Health Coalition, 2841 Riverside Drive, Ottawa K1V 8X7, (613)521-3400, fax: (613)521-4655.



## NEWS BRIEFS

### **Iraqi drugs shortages**

Severe shortages of drugs in Iraq are being reported by the medical charity Medical Aid for Iraq. According to MAI, supplies of drugs are now at far lower levels than after the Gulf War, and hospitals are struggling to manage without antiseptics, incubators, anaesthetics, needles, antibiotics and drugs of all kinds. Medical aid is supposed to be exempt from the sanctions imposed by the United Nations after the Gulf War, but aid agencies have complained of considerable practical difficulties in ensuring supplies. MAI reported shortages for medicines for children with chronic diseases such as diabetes, asthma and epilepsy. Intravenous drugs are especially scarce, and antibiotics are being given in half measures.

*July 24, 1994*

### **Kickbacks alleged**

The Ontario Ministry of Health is investigating allegations that a private

medical laboratory is paying kickbacks to doctors. The Toronto-based lab is alleged to have paid individual doctors in five communities up to \$3,000 a month each in exchange for routing patients to the lab for testing.

*July 24, 1994*

### **Healthy newborns**

The federal government is setting up a program to help low-income women get the proper nutrition and prenatal care needed to give their babies a healthier start in life. The government will spend \$85 million over the next four years providing counselling, education, and food supplements in an effort to reduce the number of low-birth-weight babies born in Canada. It is estimated that about one-third of low-birth-weight babies owe their condition to preventable, poverty-related factors. About 21,000 babies weighing 2,500 grams or less are born each year in Canada. The program is

to be community based, with groups able to apply for funding under the program.

*July 27, 1994*

### **Fewer MDs bill over \$400,000**

The number of physicians billing OHIP for more than \$400,000 a year has dropped sharply. This year, 581 physicians billed OHIP more than \$400,000, compared to 827 in the 1992-93 fiscal year. 130 billed more than \$454,500, compared with 199 in the previous year. Under an agreement between the government and the Ontario Medical Association, physicians earn 66 cents on the dollar once their billings exceed \$404,000. Once they reach \$454,500, they earn only 33 cents on the dollar.

*August 4, 1994*

*Continued on Page Eight*

## **NAFTA and De-insurance**

**E**very province has de-insured some medical services over the last two years. That means certain medical services will no longer be covered by your health insurance and you will have to pay for them yourself.

Some of the services which have been de-insured are eye exams, dental coverage for children, reversal of sterilization, invitro fertilization, and drugs covered by Pharmacare and other drug plans.

The elimination of coverage of these services has been often justified as a cost cutting measure, that in the future could possibly be reinsured.

However these services may never be covered under Medicare again.

Under the North American Free Trade Agreement (NAFTA) once a service is in the open market it is then governed by the agreement. When a medical procedure is de-insured it then becomes a commodity.

Private insurance companies would sell coverage for the procedure and doctors would sell their services privately to perform the procedure. The de-insured service would be open to market forces.

To re-insure the medical procedure the government would have to compensate those who would lose finan-

cially, the insurance companies, doctors, etc. The government could also be subject to countervailing penalties. The cost could be huge. Whether any government would want to go through the process is another question.

Unfortunately paying compensation to affected parties would also apply to new services that we may want to cover under Medicare. ▼

*From Medicare Monitor, June 1994.  
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Ottawa K1V 8X7, (613) 521-3400, fax:  
(613) 521-4655.*



## Anti-abortion terrorist kills two

A Florida physician and his escort were killed by an anti-abortion fanatic, and a third person was wounded, in the latest episode in the terrorist campaign against abortion clinics in the U.S. Paul Hill, a leader of the anti-abortion group Defensive Action, has been charged with murder after he fired a shotgun at point-blank range at John Bayard Britton, 69, a physician who worked at the Ladies Center for Abortion in Pensacola, and at Britton's escort, James Barrett, 74, a retired Air Force lieutenant colonel. Barrett's wife, June, 68, a retired nurse who works as a volunteer at the clinic, was wounded. Hill had publicly advocated "justifiable homicide" against doctors who perform abortions and had led demonstrations at the clinic every Friday for more than a year. The use of terrorism to stop abortions has become a prominent feature of the anti-abortion movement in the U.S., with more than 1,000 incidents of violence directed at abortion clinics recorded since 1977. Another physician, Dr. David Gunn, was shot dead outside another Pensacola abortion clinic in March 1993.

August 5, 1994

## Less hospital use called for

An interprovincial government report says that patients should be admitted to hospitals only on an acute-care basis if the health care system is to provide the most cost-effective care. The report, *When Less is Better*, was commissioned for the conference of federal, provincial, and territorial deputy health ministers. It says that "hospitals have often been, but should not be, the

health-care facilities of first resort... [They] should serve the severely ill who require the labour and technology-intensive services which can only be delivered in that setting." Acute-care hospitals are the greatest single consumer of health-care resources, annually costing \$30-billion — 40 per cent of the money spent on health care in Canada, the report says. The report says a significant number of patient admissions by acute-care hospitals are not warranted, referring to a number of previous studies. The report says that studies have shown that physicians who do not work under a fee-for-service system tend to order fewer patient-days in acute-care hospitals.

Carol Clemenhagen, president of the Canadian Hospitals Association, said that the report "has forgotten that hospitals are community-based agencies" and that different communities have different needs. "If you're in an urban centre, this kind of narrow role for hospitals is fine, but it has really missed the point as far as rural communities' needs."

August 12, 1994

## Sick Kids MDs go on fixed fees

Doctors at the Hospital for Sick Children in Toronto have signed an agreement to go on a fixed fee system, abandoning the fee-for-service system of remuneration. Payments for the 68 full-time and 66 part-time physicians are based on what they billed OHIP in 1993-94.

The hospital's surgeon-in-chief, Dr. Robert Filler, said that the fee-for-service system made it difficult to recruit and retain specialists. "Although our physicians made life and career decisions to work in the academic en-

vironment that Sick Kids provides, they increasingly have been attracted to centres in the United States that promised a stable income with protected time for teaching and research," he said. The physicians remain self-employed and are allowed to treat adult patients in other hospitals under the fee-for-service method. The fee is not considered a salary because the doctors are not considered employees of the hospital and do not receive benefits such as pension plans.

A similar compensation plan has been in effect at three teaching hospitals in Kingston since July 1, covering more than 200 physicians with the faculty of medicine at Queen's University, and alternative payments plans are being negotiated in a number of other teaching hospitals.

Although the agreement was signed by the Ontario Medical Association, OMA president Michael Wyman emphasized that "this is not the death knell for the fee-for-service system. Fee-for-service is still for most physicians the preferable method of payment," he said.

The OMA won a victory in the negotiations by getting the government to agree to commit \$2 million to the Sick Kids doctors' payment fund. The OMA has been stone-walling the government on alternate payment plans, refusing to allow any money for such plans to be taken from the fee-for-service pool. Under the agreement which the NDP government signed with the OMA in 1991, the OMA has a veto over OHIP's \$3.85 billion fee-for-service pool.

August 12, 1994



## NEWS BRIEFS

### Student benefit cuts criticized

The Canadian Union of Public Employees is calling the decision to deprive foreign students in Ontario of OHIP benefits "hasty" and "ill-advised". CUPE's Ontario president, Sid Ryan, said that it is discriminatory and shortsighted for Queen's Park to cut the benefits of foreign students, many of whom work as teaching assistants and researchers. They pay income tax and contribute to unemployment insurance and the Canada Pension Plan, Ryan said. Vanessa Kelly, head of the Canadian Union of Educational Workers, said that an attack by the province on powerless and disenfranchised foreign students "is an attack on the universality of the health-care system." "If you can attack one group of workers, who's next?" Kelly said. About 19,000 to 22,000 international students and about 22,000 foreign workers and their families are affected by the cuts.

The province has reversed several of the cutbacks in originally announced. The families of foreign workers who have contracts proving they are in Canada for at least three years will now be covered, as well refugee claimants awaiting appeal.

*August 12, 1994*

### Video commercials in doctors' offices

Video terminals blaring commercials are coming to some doctors' waiting rooms this fall. The Health and Lifestyles Network will be distributing programs to be shown on TV monitors in the offices of 400 pediatricians across the country starting November 1. Video Corporate Reports hopes to strike a similar agreement with an initial 2,400 family physicians. The pro-

grams will feature health "information" on topics such as colds, and nutrition, interspersed with ads from drug companies, toy makers, and other corporate sponsors. "There's nothing else like it in Canada," said Emilio Tacconelli of Health and Lifestyles Network. "In the waiting room you have a captive audience in a very controlled environment," said Tacconelli. Physicians signing a contract with the marketing firm have to agree to show the programs all day on the television monitors that are provided to them at no cost.

*August 14, 1994*

### Follow conscience on euthanasia

The Canadian Medical Association decided not to take a position on euthanasia at its August annual meeting. "The question of legalizing physician-assisted death is a matter of conscience for physicians, and therefore it does not intend to advocate a particular position on this matter," said the CMA's policy statement.

*August 16, 1994*

### Hospital accused of racism

A group of current and former employees on North York's Branson Hospital has filed complaints of discrimination and systemic racism against the hospital. Seven nurses and two support workers are complaining of wrongful dismissals, indiscriminate cancelling of duties and the assigning of demeaning jobs to qualified women — all based on the colour of their skin.

*August 16, 1994*

### Man wins discrimination case

The Ontario Ministry of Health may not discriminate because of age when

administering assistive devices for the visually impaired, the Ontario Court of Appeal has ruled. The court was ruling on a case involving Edwin Roberts, a 71-year-old man who was turned down by the Health Ministry for help under the Assistive Devices Program to buy a closed-circuit television magnifier. The Ministry decided he was too old to be eligible. The Ministry argued in court that removal of the age discrimination in the vision-aids category of the Assistive Devices Program could lead to dismantling of the program. The court said in its ruling that the Ministry had introduced no evidence to support this contention. The program, under which the government pays 75 per cent of the approved cost of the devices, provides financial assistance to persons with long-term disabilities. In 1992-93, it cost \$93 million and provided 144,183 devices for 123,500 people.

*August 18, 1994*

### Ambulance cuts called dangerous

A task force looking at problems with Metro Toronto's ambulance service has been told by ambulance workers than ambulance attendants and paramedics are suffering from overwork, high stress levels and a poor relationship with management. The ambulance service has seen dramatic cuts in funding and a consequent increase in worker complaints and dissatisfaction. The service had about 730 paramedics and attendants in 1991. That number has now been reduced to 670, with the result that response times have increased. Workers' claims were supported by Tom Alston, director of field operations, who told the task force that "because we cannot provide



## NEWS BRIEFS

the kind of coverage in advanced life support we need, there are people out there that are suffering. There's no way around that."

August 20, 1994

### MEETINGS AND CONFERENCES

#### A Picture of Health

The Ontario Federation of Labour is holding a release screening of the new OFL video, *A Picture of Health*, about the fight of front-line workers in the health care system for quality health care services and the right to care. **Thursday, September 22**, at 6:30 pm at the Ontario Science Centre, 770 Don Mills Road, Toronto. Contact Susan Wells, (416)443-7656.

#### MRG General Meeting

The Medical Reform Group's fall general meeting is being held **Thursday September 29** at the Davenport-Perth Community Health Centre, 1900 Davenport Road, Toronto. The topic for the meeting is "What does medically necessary mean?" The discussion will look at the social and economic context in which governments and other players in the health care field are defining "medical necessity".

The meeting starts at 7:45 pm. Dinner will be catered in, and will start at 6:30 pm. Please call 416-588-9167 if you are planning to come to the dinner so we will know how many dinners to order.

#### 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.

#### A Day with Rachlis and Kushner

Michael Rachlis and Carol Kushner host their first annual Toronto health policy conference, *A Dose of Strong Medicine*, on **Wednesday, November 30** at the Toronto Marriott Eaton Centre. Joining Rachlis and Kushner will be the Toronto Star's Queen's Park columnist Thomas Walkom and University of Toronto Nursing Professor Gail Donner. Contact Rosser, Munro & Associates, 4 Ferbane Place, Toronto M2J 1Y8, (416) 493-8062.

### PUBLICATIONS

#### Strong Medicine

HarperCollins has published a new book from Michael Rachlis and Carol Kushner, *Strong Medicine: How to Save Canada's Health Care System*. *Strong Medicine* investigates the problems of Canada's health care system and then offers a solution that entails strengthening the primary care sector.

*Strong Medicine: How to Save Canada's Health Care System*. Michael Rachlis and Carol Kushner. HarperCollins. Toronto, 1994, ISBN 0-00-2552817, \$28.

#### Undermining Medicare

The essays in this volume argue that studies of the Canadian health care system neglect the role of labour and leave out the effect of cutbacks on the people who do the bulk of the work: the nursing assistants, the orderlies, the cleaners. *Take Care* analyzes how the "market-driven" changes that have been initiated across the country have a profoundly negative impact on the



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quality of working life and ultimately on the care that patients receive.

**Take Care: Warning Signals for Canada's Health System.** Hugh Armstrong, Pat Armstrong, Jacqueline Choiniere, Gina Feldberg, Jerry White. Garamond, 77 Mowat Avenue, Toronto, Ontario M6K 3E3. 1994, 127 pp, ISBN 1-920059-23-6.

### Nursing in Transition

*Vital Signs* is a book about changes in nursing work. The first chapter looks at the historical developments that have led to the current conditions and relations of nursing. The second examines the role of technology in structuring this women's work, and the final chapter makes a case for women's nursing work to be understood within the context of the political economy, encompassing the household, the formal economy, and the state.

*Vital Signs: Nursing in Transition.* Pat Armstrong, Joacqueline Choiniere, Elaine Day. Garamond, 77 Mowat Avenue, Toronto, Ontario M6K 3E3. 1994, 120 pp, ISBN 1-920059-59-7.

### Proceed with Care research

The Canada Communication Group Publishing has released 15 volumes of research and analysis which were done on behalf of the Royal Commission on New Reproductive Technologies. The Commission's final report, *Proceed with Care*, was released in November 1993. Each volume cost \$29.95; the complete set costs \$350. Contact Canada Communication Group, (819)956-1596.

### Division of Surgery

*Division of Surgery* is a novel "tracing one woman's journey through and beyond" her experience of Inflammatory Bowel Disease. It is described as an "unflinching look at a young woman's determination to survive in a torturous medical environment."

*Division of Surgery.* Donna McFarlane. Women's Press. 1994, 224 pp, ISBN 0-88961-193-9, \$13.95.

### Total System Reconfiguration

The Final Report of the Essex County District Health Council's Steering Committee on Total System Reconfiguration is now available for \$25. Contact Essex County 'Win/Win' Model, 4510 Rhodes Drive, Unit 720, Windsor, Ontario N8W 5K5, (519)944-5888, fax: (519)944-0619.

### Medicare Monitor

The June issue of *Medicare Monitor*, published by the Canadian Health Coalition, contains an editorial opposing user fees, pointing out that the revenue from user fees is offset by increased administrative costs, while they deter the poor from obtaining needed medical services. Other articles deal with NAFTA and de-insurance, the planned National Forum on Health, and Health Care and NAFTA.

*Medicare Monitor*, Canadian Health Coalition, 2841 Riverside Drive, Ontario K1V 8X7.

### Network

The summer issue of the Canadian Mental Health Association's publication *Network* contains a special report on Case Management and Mental Health Reform.

*Network*, 180 Dundas Street West, #2301, Toronto, Ontario M5G 1Z8.

### Canadian Woman Studies

The summer issue of the journal *Canadian Woman Studies* is a theme issue on the topic Women and Health. More than two dozens articles focus on topics such as Breast Cancer and the Environment, Women's Occupational Health and Andocentric Science, Health Care Issues for Somali Women, Women and Smoking, Female Genital Mutilation, Midwifery Care for Immigrant and Refugee Women in Ontario, Commercial Interests and New Reproductive Technologies, and the Privatization of Long-Term Care.

*Canadian Woman Studies*, 212 Founders College, York University, 4700 Keele Street, North York, Ontario M3J 1P3. Subscriptions \$32.10.

### ARCHTYPE

The May/June issue of *ARCHTYPE* is a double issue dealing with health care form. Articles look at topics such as services for kidney failure; user fees; how consumers can influence change in the health care system; black women taking charge of their health; mental health reform; an accessibility review of community health centres; incorporation of physicians; long-term care; and injured workers' responses to Workers' Compensation reform.

*ARCHTYPE*, c/o Advocacy Centre for the Handicapped, 40 Orchard View Blvd., #40, Toronto, Ontario M4R 1B9.



## Canadian doctors vote not to reject user fees

Physicians 'a greedy bunch' in defeating resolution at CMA convention, medical reformer asserts

BY JOAN BRECKENRIDGE  
The Globe and Mail

TORONTO — A recent decision by members of the Canadian Medical Association to strike down a proposal opposing user fees shows how money-hungry and misguided many doctors are, a spokesman for Ontario's Medical Reform Group says.

"They're a greedy bunch," Dr. Gordon Guyatt said yesterday after strongly condemning the

move that upset the reform group was a vote this week at the CMA's annual convention in Montreal. The membership refused to endorse a CMA resolution that opposed asking patients for cash up front to help finance health care

that they don't seem to understand the negative effects such fees have on some patients. "Physicians are ready to penalize the poor, elderly and disadvantaged."

Dr. Guyatt said in a telephone interview from Hamilton.

"The individual doctors were saying, 'We're angry because we don't think we're being paid enough, and who cares about being socially responsible.'"

Dr. Hugh Scully, chairman of the CMA's working group on health-system financing, said yesterday that the CMA leadership is totally op-

tion, and putting more money in doctors' pockets.

"It probably does deter frivolous use for those who can afford to pay them, but it creates a situation that interferes with access potentially for the poor, the disadvantaged and the elderly," he said in Toronto.

"It can wind up being a net cost to the system," Dr. Scully said.

He pointed out that when New

solution was rejected because there was confusion among the members. While the leadership was signalling that user fees were a bad idea, a CMA survey found a majority of doctors weren't against them.

The recent survey was sent to 4,000 doctors. Preliminary results show that 58 per cent of those who responded supported the idea of user fees as a potential way to help fi-

nda's overburdened system, Dr. Scully said, convinced it's a bad haven't bought into it

Canadian physician in misguided fashion, went back to user fees," he

## Specialists disgruntled with OMA

BY MATT BORSELLINO

TORONTO — The fragile peace within the ranks of the Ontario Medical Association seems to be unravelling with critics complaining about both new and old issues.

One major area of concern is the seceding from the OMA and start a

tion on nephrology and a driving force for an independent appeals process.

"But all sides must create and endorse an appropriate methodology and appeal process," he is quoted as saying in a recent issue of the OMA

directors, but there has been little reaction since.

"We're discouraged there's been so little communication and consultation," he said recently in a telephone interview. He did not know how long he might wait before pur-

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## OMA peace threatened on many fronts

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of the OMA board is scheduled for the end of July.

Developing an appeals process was discussed at the June board meeting and "is still in development," according to OMA spokesperson Jean Chow. But only the executive committee's proposal for a CTC appeals process was discussed at the meeting, not the 12-page document developed by Dr. Meudelschinn's group.

On another front, a proposal to pare the number of board meetings from 10 to 12 was also discussed

however, is something "a good committee always does," Chow said.

District 4 director Dr. Andrew Zawadowski is among those who believe reducing board meetings and reducing the power of the finance committee as the association's fiscal

watchdog are things that may disturb "the balance of power" and are things the OMA could well do without.

Instead of retrenchment, the OMA should be concentrating on

the social contract, he told District 4 members in a June 30 letter.

"It's not nearly tough enough now. The result has been the legal costs associated with litigating the government's breaches of the agreement, he said in an interview.

Dr. Zawadowski, who will run again for a seat on the board, doesn't think board solidarity is necessarily such a good thing.

Board behavior, he writes in the letter,

"It bothers me that the board and executive have had trouble backing down on the issue

let them know.

"The OMA is not General Motors," he added. "It's an association with major political ramifications. It develops policies, not products... I'm worried about the corporate image. I'm worried about the views of my members, and how they are served."

Another decision taken at the annual meeting which is attracting criticism is an across-the-board 2% holdback of fees.

The Medical Reform Group of Ontario is speaking out against the