

MEDICAL REFORM

Newsletter of the Medical Reform Group

Issue 125

Volume 22, Number 4

Spring, 2003

NEXT STEPS ON ROMANOW

Rosana Pellizzari

It has been just over 4 months since Commissioner Romanow submitted his final report to the House of Commons, and 2 months since the First Ministers signed the 2003 Health Accord. "The Health Accord is a major first step in fixing Medicare", Mr Romanow told the Standing Committee on Health at its April 3rd meeting in Ottawa. He outlined his reasons for his support.

First, he believed the Accord affirmed the five principles of the Canada Health Act. They recognized the need for greater accountability and transparency by replacing the current federal transfers with a dedicated Canada Health Transfer. According to Mr. Romanow, the agreement not only heralded new federal investments, but also outlined consensus on targets and objectives, and led to a commitment on the First Ministers part to monitor population health and direct Health Ministers to address disparities in health status.

But the outcome that proved most significant to the Commissioner, was the agreement to form a Health Council to facilitate and direct the many recommendations made in his report. However, Mr. Romanow warned the Committee that the money in the Accord, purported to be between \$30 and \$35 billion over the next several years, is less than he recommended, and less than recommended in the Senate's report, chaired by Senator Kirby. He warned that the details for the \$16 billion health reform fund were sketchy at best. That the \$2.5 billion immediate "top-up, ear-

marked to address urgent needs like waiting lists, could easily be squandered, and that the bulk of the promised funds will not be accessible until late in 2003, jeopardizing the possibility to move forward and creating delays in implementation.

Mr. Romanow went on to warn the Committee that the Health Accord could be rendered ineffective if there wasn't urgent attention given to building health infrastructure and the expansion and "alignment" of health human resources. He urged the federal government not to lose sight for the need to address chronic illness by investing in strategies to prevent obesity, diabetes and sedentary lifestyles. He recommended a national and coordinated strategy.

As he had in his report, Commissioner Romanow reminded the Standing Committee for the need to "modernize" the Canada Health Act to include homecare and prescription drugs. He

reminded Ottawa of his recommendation that the federal government pay for 25 per cent of health care funding by 2005-6.

The 2003 Health Accord commits governments to establish a Health Council by May 5, 2003. Mr. Romanow warned that the Council should not be an additional layer of bureaucracy. Given its important role, he warned that the mandate, membership, resources and agenda should be very thoughtfully determined.

In the question and answer period which followed, Judy Wasylycia, MPP for Winnipeg North and former NDP health critic, expressed disappointment that the federal government did not officially adopt the recommendations of the Commission as a blueprint. She asked Mr. Romanow to comment on the private/public funding of health care. To this, Mr. Romanow responded that there was no evidence to support private funding, and that he hoped that provinces would set ideology aside in order to do the right thing.

Doing the right thing, though, seems far from the practice here in Ontario, where the Tories seem committed to proceeding with their private-public hospital partnerships and the privatization of MRI testing. Beyond ideology, according to an NDP media release on January 28th, it's probably political donations that fuel the privatization in Ontario. Three companies bidding on the Royal Ottawa Hospital all donated to the Tories: Health

INSIDE

PJ's Adventure.....	3
Ontario Election.....	4-9
US Study Tour.....	10
A Member Returns.....	17
Guyatt Columns	11-12, 18
Principles & Policy.....	13-16

(continued on page 2)

MedicalReform

Medical Reform is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at \$50 per 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, or sent by e-mail to <mrg@web.ca>.

Send correspondence to *Medical Reform*, Box 40074, RPO Marlee, Toronto M6B 4K4. Phone: (416) 787-5246; Fax (416) 782-9054; e-mail: <mrg@web.ca>. Opinions expressed in *Medical Reform* are those of the writers, and not necessarily those of the Medical Reform Group.

Editorial committee this issue: Mimi Divinsky, Gordon Guyatt, Janet Maher.

The Medical Reform Group 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 contribution of all health care workers is 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.

Minister Tony Clement received \$10,000 from Aecon, \$2,500 from Borealis Infrastructure and \$2,500 from Ellis Don. Borealis also donated almost \$5000 to the Conservative Party.

NDP research has uncovered that Aecon, Borealis, Ellis Don, and two other Tory Party funders, SNC and PCL, are all involved in the bidding for the private William Osler Hospital in Brampton. According to the NDP, Buttcom Ltd, another bidder in the Brampton deal, donated \$17,815 to the Tories since 1995. But it isn't only provinces like Ontario who are failing to do the right thing.

The same week that Mr. Romanow was appearing before a House of Commons committee, the Liberal dominated Standing Committee on Industry, Science and Technology decided to put off an examination of the drug patent rules until late June. This decision was reversed after a public outcry, organized by the Canadian Health Coalition, managed to convince Committee members to proceed with a review of the "evergreening" tactics meant to keep cheaper priced generics off the market at their June 2nd session.

Commissioner Romanow recommended that Canada review the laws that allow brand name companies to block generics by alleging patent infringement. It is estimated that this costs Canadians \$1 billion a year in increased drug prices.

Canada and the U.S are the only two industrialized countries to allow this "automatic injunction" of 24 months of market exclusivity to brand-name drug manufacturers. Lobbyists from companies such as AstraZeneca and Glaxo Smith Kline, were in Ottawa in early Ottawa when the original delay was announced.

Dave Keon, President of Canadian Generic Pharmaceutical Association, accused the brand name lobbyists of "high-jacking" the process. The reversal of the decision has been hailed by the Canadian Health Coalition as a major victory.

But it is a small one. If our politicians are to keep on track, and the Health Accord does not even keep on the track of 25% federal health care funding by 2005-6, it will require the vigilance of citizens and activists across the country. Clearly, the next step is the formation of the Health Council in early May. The way in which the Council is constructed and mandated will send a clear signal about the commitment, or lack of, to implementing the Commission's vision.

With the invasion of Iraq, and the SARS outbreak, we can be forgiven for being distracted in the past month. However, the health care reform agenda in Canada needs our attention if it's to look anything like what was discerned by Romanow. ♦

PJ'S VERY EXCELLENT ADVENTURE

Janet Maher

Steering Committee member PJ Devereaux reflected recently on his experience as the lead researcher on the series of investigations on investor owned private for-profit health care at McMaster University that have kept him at the centre of one of the most contentious health care debates in many years. He spoke recently with Janet Maher, on the lessons of that work.

JM: Can you explain to me what led to the systematic review?

PJ: I was reading the book “Clear Answers” by Kevin Taft and Gillian Steward and I was struck by a passage in the book that described part of the debate in the Alberta legislature over bill 11 (the private for-profit health care delivery bill). In the debate an opposition member stated there were studies suggesting investor owned private for-profit health care was more expensive and resulted in poorer health outcomes. Ralph Klein remarked you have your studies, we have our studies. The implication of his comment is that one can learn little from empirical studies. Upon reading this I realized that health policy had failed to learn the lesson that medical research had learned 20 years earlier. The lesson being that the clearest answer to any research question comes from bringing together all of the high quality studies that have addressed the question of interest. This process of undertaking a ‘systematic review’ enhances the statistical power available to correctly answer the research question and enhances our ability to avoid assuming chance findings are real. Because there were no true ‘systematic reviews’ to inform this important health policy issue, and the unsupported but nonetheless prevailing accepted wisdom in the media was that everything that was private in health care was better we decided to undertake a systematic review to inform the issue.

JM: Can you explain the design of your research?

PJ: Sure. And I want to note that this is part of on-going work which has had the participation of many other MRG members (Gordon Guyatt, Ted Haines, Ahmed Bayoumi, Deborah Cook, David Haslam, and Maureen Meade) besides myself.

The point of our first two systematic reviews was to look precisely at the issue of health outcomes in investor owned private for-profit versus private not-for-profit health care facilities. As stated above a systematic review provides the clearest answer to any research question by bringing together all of the high quality studies that have addressed our research question. Because we did not want to introduce any bias into the selection process of studies addressing our research question we trained personnel to remove the results from the studies with a black marker.

Our eligibility criteria were based on the design and methodology of the studies not their conclusions. Therefore, after this ‘masking’ process we then evaluated the studies in duplicate to determine if they fulfilled our eligibility criteria. As a result of this process we could not select studies based on their findings/conclusions because we were unaware of them.

The first systematic review focused on hospital death rates and we began by reviewing over 8,000 citations of studies. Through our masking procedure described we identified 13 publications of 15 studies that fulfilled our eligibility criteria and were included in our hospital mortality study.

This systematic review demonstrated higher death rates in the investor owned private for-profit hospitals and was published by the Canadian Medical Association Journal in May of 2002. Because our findings challenged the prevailing accepted wisdom at the time it caused quite a stir. This stir was intensified because our results suggested a change to investor owned for-profit hospitals in Canada would result in an extra 2200 deaths annually and this is in the range of how many Canadians die each year from colon cancer, motor vehicle accidents, or suicide.

As it turned out, this research was being completed just as health commissioner Roy Romanow was completing the investigative part of his inquiry and we presented him with the findings. He was impressed and stated publicly that he thought the findings were compelling and directly relevant to Canada.

The second systematic review focused on investor owned private for-profit versus private not-for-profit death rates in the outpatient setting. In this study we used the example of dialysis care and the results were published in November by the Journal of the American Medical Association. The findings were consistent with our first systematic review (that is the investor owned private for-profit facilities had higher risk adjusted death rates compared to the private not-for-profit facilities).

JM: Can you describe the reaction on the second round?

PJ: Given that this was the second time around for us with essentially the same message—death rates are demonstrably worse in the investor owned private for-profit settings—and that both Romanow and Senator Michael Kirby were hotly debating this very issue as they prepared their reports for public release, meant that I was given a lot of opportunities to discuss our results with many varied types of people across the country. In addition to speaking to and debating with health researchers at universities and hospitals across the country, I was also invited to share my findings with grassroots activists, advocates and the public at large at several forms in a number of provinces, and in Quebec, in a special conference on health care at the National Assembly, attended by leading provincial bureaucrats.

JM: I seem to remember hearing of a challenge with Alberta premier Ralph Klein—what happened there?

(continued on page 4)

PJ'S VERY EXCELLENT ADVENTURE (continued)

PJ: Well, shortly after the second study results were released, I was invited to Alberta by the Friends of Medicare for a series of public meetings and university lectures in Calgary, Lethbridge and Edmonton. The Alberta media asked if I had any message for their premier, long reputed as an advocate for opening health care to investor owned private for-profit health care. I indicated I was keen to speak to him, either publicly or privately, to summarize the results of our research and its implications for his plans.

This was personalized by the media in the following days as a challenge to Premier Klein, carried by the media there directly to the Premier. He eventually declined, pleading the pressure of his preparations for the first ministers meeting on health.

JM: I know you had a direct meeting with Romanow, and presented to his hearings. How did you get through to Kirby?

PJ: Well, directly, not much at all [MRG member Joel Lexchin appeared on our behalf at the Toronto hearings held by Kirby in the fall of 2001 prior to our systematic reviews coming out].

As with Romanow, we were eager to communicate our results, and sought meetings with Kirby, but he declined, though that did not stop him commenting on the results. Kirby felt our research was important enough that he commissioned a review by an economist associated with the Atlantic Institute for Market Studies. Basically this economist tried to use anecdotal evidence to dismiss our findings which is what our research is all about avoiding (that is he failed to understand that it is only through a systematic bringing together of all of the high quality research evidence that we can understand the true effect).

It would seem somewhat surprising that if Senator Kirby was sincere in his desire to understand this issue that he would not have asked us about our research or more importantly asked us to respond to his commissioned report on our study. Senator Kirby's conflict of interest as a

member of the board of directors of a giant investor owned private for-profit nursing home company may have had something to do with his decisions. .

JM: You speak powerfully of the role of the media in this affair. I wonder if you can speculate a little on why you think they initially paid little attention, and then turned out to be so helpful in spreading the word?

PJ: Well, I think there has been a systematic undermining of everything in the not-for-profit sector, be it public or private, throughout the last few decades. It is to the point that the majority of people (and definitely the media) think everything in the not-for-profit sector is slow and inefficient and everything in the for-profit sector is lean mean and efficient. I believe this characterization is inaccurate and essentially the result of the fact that the not-for-profit sector is under a completely different level of scrutiny than things in the for-profit sector. The media and public have enormous access to information on the running and management of our not-for-profit institutions whereas it is completely the opposite case with the for-profit institutions. In fact the for-profit sector has no obligation and no desire to share any information, other than their successes, with the public/media. It is not until things have gone so awry (e.g. ENRON, Worldcom) that we finally hear that a for-profit institution has squandered the savings of hundreds of thousands of people. Because of the differential access to information it is not surprising, but nonetheless disappointing, that the media initially was if anything supportive of investor owned private for-profit health care.

Why I think the media publicized our research so much was the media loves controversy and our research flew in the face of the accepted logic and it was a national hot issue of debate. What is extremely heartening is that our work has gone a huge way toward reversing the misperceptions that investor owned health care is superior. ♦

MRG STUDIES PROVINCIAL ELECTION CHOICES IN ONTARIO

The coming provincial election gives Ontarians some important choices—particularly in regard to the future of health care. We present here a summary of the issues and approaches members can expect to see debated as the election process moves into high gear.

CRITIQUE OF THE NDP HEALTH PLATFORM

Gordon Guyatt

The NDP presents its program in the form of 10 “practical solutions” to Ontario’s health care problems. I’ll use their structure and comment on the first seven, adding some comments on what is missing and a bottom line conclusion.

Make sure feds pay their fair share

This recommendation is one with which every provincial party, whatever its political stripes, will agree. There is nothing to lose in criticizing the federal government, and no cost to the promise to fight for more money. Beyond that, any provincial government that doesn’t proceed with further tax cuts is on very strong ground demanding more federal money.

The NDP is correct in its analysis that the federal-provincial accord came up short in terms of the new federal funding that Roy Romanow recommended. While their enthusiasm for further tax cuts compromises any high moral ground the Conservatives might claim while making this demand (after

(continued on page 5)

CRITIQUE OF THE NDP HEALTH PLATFORM (continued)

all, if you are cutting taxes, where is the desperate need for federal money for health care?) the NDP's disinclination to tax-cut makes their argument stronger.

Cancel private MRI and CTs

While their terminology leaves something to be desired (we would prefer clearer distinctions between funding and delivery, private for-profit and private not-for-profit, and between investor-owned and small business models of for-profit health care provision) the NDP's strident opposition to for-profit provision is on strong evidentiary ground. A systematic review of all high-quality studies comparing private for-profit and private not-for-profit hospitals done by a team of researchers led by McMaster cardiologist and MRG steering committee member PJ Devereaux, showed higher death rates in for-profit hospitals. Devereaux's second systematic review demonstrated similar higher death rates in largely outpatient for-profit dialysis facilities in comparison to not-for-profit facilities.

The consistency of these findings, the fact the plausible biases in the original studies were against the not-for-profit providers, and the easily identifiable mechanism (15 per cent or so of total income that not-for-profit providers can spend on patient care must go, in for-profit firms, to ensuring that investors get their anticipated return on income, necessitating corner-cutting in delivery of care) all suggest a valid and generalizable finding.

The likelihood that investor-owned for-profit providers will, to ensure profits, compromise on quality of care, ultimately yielding adverse patient outcomes, is not the only reason to shun for-profit provision. For-profit hospitals in the U.S. have an unenviable record of health care fraud. The biggest American fraud bust involved the nation's largest for-profit hospital chain, then known as Columbia/HCA Healthcare. At the end of 2000, the company pleaded guilty to

cheating government programs and agreed to pay a total of \$1.7 billion in fines and penalties, the largest fraud settlement in U.S. history. Another large investor-owned for-profit chain, National Medical Enterprises (NME), suffered a fraud conviction with a total settlement of \$379 million.

These examples, while among the largest, are not unusual. The U.S. Justice Department estimates that \$100 billion, or 10 per cent of the \$1 trillion Americans spend on health care each year, may be lost in fraud. When health care delivery is a business, fraud is often too easy, and too tempting. Ontario puts itself at risk of such fraud, and the cost of prosecuting and policing it, when it moves to investor-owned for-profit health care provision.

The NDP's proposal to eliminate investor-owned for-profit diagnostic facilities is well justified.

Cancel P3 hospitals

Public-private partnerships reflect a growing movement in hospital financing. The Ontario Tories are currently planning two new hospitals, one at the Brampton campus of the William Osler Health Centre and another at the Royal Ottawa Hospital, that would be designed, built, financed, owned and operated by the private sector. The hospital board will use public money to lease the hospital from its owners.

The idea of these public-private partnerships (P3s as they are called) is to help governments raise money to pay for public services, such as hospitals, which require massive start-up investments. We'll be able to build more hospitals, advocates argue, if private dollars are available for initial funding.

The argument doesn't hold up, in theory or in practice. The problem in theory is that public borrowing is always more expensive than private borrowing, and so the government will end up paying the additional costs of private financing.

That is what has happened in Britain, which has conducted the largest experiment with P3 hospitals to date. Ultimately, resources that should go to patient care end up in the pockets of private financiers.

While the NDP is on strong ground in opposing the P3 plan, whether they would be able to make good on their promise to cancel the proposed deals depends on what the government has signed by the time they lose office (if, indeed, that is the outcome of the election).

End home care privatisation and "ensure adequate support" for the elderly

The Tories have engineered a dramatic change in the home care sector, which has moved from largely not-for-profit provision to largely investor-owned for-profit provision. The same arguments I outlined above with respect to diagnostic services support the NDP plan to move back to not-for-profit providers.

The NDP platform implicitly promises more resources for home care, without being at all specific about how much is needed, or how much it will cost. The proposals are in line with Roy Romanow's recommendations and, if implemented, might not only provide much-needed support for family members providing care, but ease the burden on overcrowded hospitals by facilitating out-patient management.

Establish 100 new community health centres (CHCs)

While the evidence supporting multidisciplinary integrated health care is not strong, the logic is sound, and over two dozen reports in the last two decades (including both Romanow and Kirby) have recommended the transition. The number 100 chosen by the NDP is no coincidence—that is the number of communities that have let the government know they would provide

(continued on page 6)

CRITIQUE OF THE NDP HEALTH PLATFORM (continued)

local support for community health centres. The NDP action would constitute a welcome change from the effective freeze on CHCs which has characterized the Tory period in power.

Cut medical school tuition, more full-time nursing and nurse practitioner positions

Medical student tuition has risen to outrageous levels of well over \$10,000 per year in most Ontario universities, compromising access to young people from low-income backgrounds. The NDP proposals regarding nursing care go hand-in-hand with their proposal for CHCs which one would expect would be the largest employer of an increased volume of graduating nurse practitioners.

Roll back long-term care fee increase and introduce tough standards for long-term care institutions, hospitals, and community care

Paying for long-term care by direct charges to recipients and their families is, in effect, a special tax on the dependent and their support systems. Paying for long-term care through taxes is a more equitable way to provide the needed resources.

As with other aspects of their platform, the NDP provides little detail about exactly what their proposal to implement "tough standards" would actually mean. While it isn't difficult to read between the lines in other aspects of the platform,

this one is more challenging. We have little evidence to tell us what minimal staffing standards would be appropriate, and evidence that quality monitoring improves outcomes is, at best, limited. Implementing this proposal intelligently would likely prove challenging.

Streamline training and accreditation of foreign trained health professionals

In private conversations, NDP representatives acknowledge the problem that facilitating jobs in Ontario for foreign-trained physicians risks, in many instances, the rich robbing the poor. On the other hand, having large numbers of foreign-trained physicians in Ontario unable to qualify while many Ontarians can't find a family doctor is problematic. Facilitating system entry remains questionable until we can be assured that the policy will not encourage a flight of trained health professionals from less prosperous nations to Canada.

What is Missing from the NDP proposals?

The NDP platform fails to get specific about the costs of their proposals. While disappointing, one can understand that to do so would be challenging, and may not make sense politically at this stage of the incipient campaign. Given Ontario's economic situation and the NDP's lack of interest in tax cuts, funding the proposed expansion in health care should not be problematic.

The NDP has read the Romanow report well. Their proposals are completely consistent with the report. Of particular note is the absence of any mention of increased support for hospitals. This is consistent with Romanow's virtual omission of hospitals from his report, and with evidence that suggests that increases in hospital spending can absorb huge amounts of health care dollars while producing little benefit.

At the same time, hospitals need a government that will provide a plan for realistic and stable hospital funding. Perhaps the NDP's mention of better working conditions for nurses implies a promise for expanded hospital funding. Certainly, to deal with increases in nursing incomes and job situation that would make hospitals more attractive to nurses will require substantial increases in hospital allocation.

The Bottom Line

Roy Romanow's recommendations were well thought-out and largely evidence-based. The NDP proposals are completely consistent with the report, and provide initiatives in the right areas of health care delivery. A government that implemented these proposals would lead to a better-functioning health care system in Ontario. ♦

THE LIBERALS: STYLE OR SUBSTANCE

Ted Haines

The introductory photo has leader Dalton McGuinty grinning at a patient's bedside. For citizens who are weary and wary of political messaging, the meaning of the image may be ambiguous. And a close look at the Ontario Liberals' proposals suggests that while they are impressively crafted, they are lacking in cohesion and substance at key points. Their touchstone is the

Romanow Commission. Here they set up a contrast with the Tories.

'Privatization takes us backward, to an era when we received only the care we could pay for out of our pockets. Romanow called on us to strengthen our public health care system, not give up on it. To modernize, not privatize, Medicare. We couldn't agree more.'

And... 'The Harris-Eves government

believes in more private health care. They allowed private MRI and CT clinics, opened the door to private hospitals, cut homecare services and raised fees for seniors living in nursing homes.'

They characterize the Harris-Eves agenda as one of 'creeping privatization' and cite Romanow (and indirectly the work of Devereaux and others) that there is no

(continued on page 7)

THE LIBERALS: STYLE OR SUBSTANCE (continued)

evidence that this 'will deliver better or cheaper care, or improve access (except, perhaps, for those who can afford to pay out of their own pockets).'

Indeed, they promise to 'cancel the Harris-Eves private clinics'. Instead they will support the expansion of diagnostic imaging services in hospitals, noting that 'many communities have already raised money for a new MRI or CT for their local hospital, but have been denied operating funds by the Harris-Eves government.'

Other measures proposed 'to strengthen our public health care system' include:

- Providing adequate multi-year funding for hospitals and health sciences centres;
- Intention to 'invest in home care'. 'We will remove the arbitrary Harris-Eves limits on homecare. If you require care and want it in your home, and that care costs less than sending you to a hospital or nursing home, we will make sure you get it'. They further state: 'Our long-term vision is to make homecare a medically necessary service';
- Improving standards for nursing homes. The Tories had removed provisions that nursing home residents receive at least 2.25 hours of nursing care daily and 3 baths per week; these will be revisited. In addition, the Liberals propose better regulation of nursing homes. Licensing and inspections systems are currently in disarray. Further, they will 'cancel the Harris-Eves 15 per cent increase in nursing home fees';
- Establishing 150 'family health teams' across Ontario. The Liberals will work with communities to create such 'teams' that meet local requirements. While there is no specific reference to Community Health Centres, they mention as a 'Success Story' the Group Health Centre of Sault Ste. Marie. They talk of improving incentives to attract and retain doctors for under-served communities;
- Intention to 'hire 8,000 new nurses' and to fund more positions for nurse practitioners. 'Our goal is to have 70 per cent of registered nurses working full-time, up from only 50 per cent today';
- Working 'with medical schools, universities and colleges to prepare new professionals to practice in family health teams'. They recognize that students who live or train in under-served areas are more likely to practice there and so promise to 'accelerate the development of the Northern Ontario Medical School and the Windsor medical school satellite campus.' There is talk in generalities of making 'medical tuition more affordable'. They intend to increase medical school enrollment by 15 per cent and also increase the number of family medicine residency positions. A creative notion is to provide loan forgiveness to students who choose to train in family medicine. There is general talk of removing barriers to practice for qualified foreign-trained physicians.

The Liberals further demonstrate some forward-looking, provocative thinking and understanding of the significance of health determinants with proposals such as:

- Creating a 'Family Medical Leave Act to provide up to six weeks of job-protected unpaid leave to help you care for a member of your family';
- Intention to 'invest in community mental health agencies to improve services, including family self-help, crisis intervention and community treatment' as well as supportive housing for those suffering from mental illness. Here they refer to the links between inadequate mental health services and homelessness;
- Restoring the nutritional allowance for expectant mothers on social assistance, cut by Harris-Eves;
- Banning the sale of junk food in elementary schools;
- Mandatory daily physical activity in schools;
- Promoting healthy workplace

practices;

- Replacing Ontario's coal-burning plants, the biggest single sources of air pollution, with cleaner energy sources.
- It all sounds admirable, but on a bit of scrutiny, gaps appear:
- Recognizable obfuscation around 'privatization'. You won't find the terms 'investor' or 'profit' in their platform, whereas the evidence is that profit-taking is the key to the adverse effects on health outcomes in for-profit facilities, rather than private versus public ownership status as such;
 - Lack of clarity on P3 ('Public-private partnership') hospitals. They say that Harris-Eves 'opened the door to private hospitals' but don't indicate what their approach will be;
 - Lack of mention of funding sources for hospital support and the various 'investments' promised. No reference is made to advocating for an appropriate level of federal contribution;
 - Lack of intention to deal with the destructiveness and inefficiencies of competitive bidding through Community Care Access Centres, for example, for home care services, or with the massive expansion of investor-owned for-profit provision in this sector;
 - Intention to pass a 'Commitment to Medicare Act that will make universal, public Medicare the law in Ontario' but what for? Where does that leave the Canada Health Act? And in general, apart from respectful mention of Romanow, the Liberals offer no specifics of how his recommendations will be implemented in Ontario or of cooperation with the federal government and provinces.

These deficiencies raise doubts about where the Liberals really stand on genuinely acting on publicly funded, not-for-profit health care. In the photo, the patient is grinning back at McGuinty: the patient may have more insight into his policies and postures than McGuinty realizes. ♦

LET ONTARIANS DO THE MATH

Janet Maher

As our current government in power, the Ontario Tories have the advantage in timing the next provincial election to their best advantage. In the absence at press time of a formal campaign platform, we can get a few ideas of the direction they can be expected to take from the 2003 budget. One of the recurrent themes of the March 27th budget was accountability—of the federal government, of hospitals, schools and universities and municipalities, but remarkably little regarding the provincial government itself—perhaps not a surprise given the cynical relocation of the presentation of the budget from the legislature to a corporate shop floor deep in the heart of the 905 region.

The sale of hydro assets gets hardly a mention. Still the budget presented by Finance Minister Janet Ecker manages to touch some of the hottest buttons on the minds of Ontarians this spring. Will there be health care for me and my family when I need it? Will my child get an education at primary, secondary, post-secondary level and be competitive in the 21st century? How much will it cost?

As the Finance Minister reminded several times during her budget speech, the government sees itself as continuing the Harris legacy in that “tax cuts are the key to [our] prosperity.” In addition to

- the personal income tax cut of 20 per cent promised and then withdrawn last year reannounced for 2004;
- the readjustment of the floor for the provincial surtax to \$75,000 taxable income;
- additional support of an average of \$300 for 165,000 caregivers of seniors and persons with disabilities; and
- rearrangement of tax credits for seniors to reduce the education portion of property taxes by an

average of \$475 for nearly a million senior households; the remaining tax cuts are focused on the corporate tax payer.

These include

- the further 10 per cent reduction in capital tax, and
- a range of more specific tax incentives to support industry-based innovation and skills training, and new energy generation.

As well, the chair of management board has been instructed to find and eliminate an additional \$500 million in waste in government waste.

Specifically in the area of health, the Tories expect the additional \$2 billion they will spend on health over last year will include spending of

- Approximately \$275 million for physicians and other health care providers in the implementation of primary care reform
- Almost \$200 million to cover higher utilization of Ontario drug programs
- A further \$193 million for diagnostic and medical equipment upgrades
- \$250 million for a 5 year comprehensive mental health reform
- initiation of a \$1 billion Cancer Research Institute of Ontario
- enhancements and expansion of long-term care facilities to address persistent bottlenecks in hospitals and existing long term care.

Perhaps what is claimed as the most interesting innovation is the implementation of stable multi year funding for continuing core services in colleges and universities, schools and hospitals. This has been a bone of contention for years with the so-called transfer agencies, and will certainly be welcome.

What is notable about this funding is that despite the anticipated pressures of the double cohort at colleges and universities; despite the findings of Romanow in the

case of health; and despite the recommendations of Rozanski in the case of schools; all of which indicated pressure points for funding which had been neglected in the previous 5 years, the regime of stable core funding is slated by the finance minister to grow over the next three years only at roughly the rate of inflation.

In her speech, Ecker indicates that this commitment is for continuing core services based on current service volumes and other funding decisions. She further notes that “any additional funding will be subject to three key factors: economic growth, the level of federal government support and results to be achieved through greater accountability,” a process of setting targets and benchmarks she will work with hospitals, school boards, colleges and universities to achieve.

The government has reserved for its next budget a “dialogue” with municipalities, the fourth agency traditionally supported by provincial transfer payments, with the objective of completing a multi-year funding agreement with them for the cost sharing of municipal services. In the interim, they have found some funds to enhance municipal infrastructure in the area of clean water and waste management, primarily in small towns and rural districts.

In spite of passionate pleas from friends of the government on the need to invest in programming for the early years, the only new spending announced for the children’s services sector is an increase of some \$200 million targeted to the protection of children at risk of neglect and abuse and support for the families of children with autism.

On the day after the budget and writing on behalf of the Ontario Alternative Budget Group, labour economist Hugh Mackenzie characterized the provincial government proposals in the following terms:

LET ONTARIANS DO THE MATH (continued)

Tax cuts are front-and-centre — cuts with a full-year cost of over \$1 billion.... The tax cut projections don't include the ultimate costs of reductions promised in this budget, but not fully implemented yet. It doesn't count the corporate income tax cuts that have been put back on line, effective January 1, 2004. That schedule will result in a reduction in corporate tax revenue of \$2.6 billion by the time it is fully phased in...

[According to Mackenzie, the March 27th budget.] doesn't count the cost of eliminating Ontario's personal income surtaxes — what used to be called the Fair Share Health Levy. When the surtaxes have been eliminated completely, they will cost Ontario \$3.1 billion — 94% of which will go to the 5% of taxpayers with incomes over \$100,000 a year.

On the expenditure side, the Government makes a lot of noise about new investments in health care; elementary and secondary education; and colleges and universities.

Announced multi-year funding for hospitals provides increases of \$500 million, or 5 per cent, for 2003-4 and

\$300 million, or 3per cent for 2004-5...basically only inflationary cost increases since 2002-3...[with little...to address the financial crisis that hospitals are in today....

What the government didn't say is that it took \$967 million of the new Federal money announced in February, 2002 in advance and used it to offset the revenue loss from the fact that they didn't sell Hydro One.

In post-secondary education, operating grants are projected to increase by \$200 million in 2003-4; another \$200 million in 2004-5 and \$100 million in 2005-6. This increased funding, however, falls far short of what is needed to enable these institutions to meet the challenges of the double-cohort and avoid further cuts to other programs. Based on current projections for increased enrolment in 2003-4 and beyond, \$200 million in additional funding will not even accommodate the increased enrolment, leaving nothing to deal with the impact of increased costs.

In elementary and secondary education, the Government claims to

be implementing Rozanski. In fact, it is doing the opposite. The projected funding for school boards over the next three years will deliver roughly 55% of what Rozanski recommended. And by 2005-6, when Rozanski will supposedly have been fully phased-in, the school system will be more than \$1.6 billion behind what Rozanski recommended. That compares with the catch-up funding that Rozanski recommended of \$1.4 billion (a total of \$2.1 billion, \$700 million of which was new investments).

Elementary and secondary education funding will be \$200 million further behind it was when Rozanski was appointed, using Rozanski's logic and method.

Eves is counting on the good will of Ontarians when they see commitments to the pressure points like primary care reform and water safety. The coming election will be the testing ground for his estimation that Ontarians will pay more attention to what he says than what he does. ♦

AMERICANS STUDY CANADA: THE AMSA COMPARATIVE HEALTH POLICY TOUR

Gary Bloch

"[The tour] gave me a firsthand look at the Canadian health care system. Now when I talk to people about single-payer, I can say 'I've been there, I know it can work, because I've seen it working.'"

— American medical student

In January, the Medical Reform Group hosted a group of medical students from across the United States, representing the American Medical Student Association, on a study tour of the Canadian health care system. Over three days, the fourteen students explored, in-depth, the realities of planning, working within, and being served by, our system of care. Their enthusiasm for our system provided

exciting validation for our efforts to preserve a single-payer, equitable approach to providing health care for Canadians.

The group began their tour in Hamilton, with an introduction to the Canadian health care system. This was followed by talks on occupational health services, and medical education in Canada. That evening they socialized and compared ideas on health policy with medical

students from the University of Toronto. The following day was spent in Toronto, with presentations by experienced health care providers on medical and surgical specialty services, hospital administration, emergency services provision, and residency training.

They discussed how well the system responds to health care recipients with a patient with years of experience in the

(continued on page 10)

AMERICANS STUDY CANADA: THE AMSA COMPARATIVE HEALTH POLICY TOUR (continued)

system. Finally, the group explored challenges of providing primary care to the marginalized with inner city physician Philip Berger.

To connect the talk with reality, they were led on a tour of the innovative Rotary Club infirmary for homeless men at the at Seaton House Men's Hostel and were then guided around key sites of health care provision in Toronto.

The students expressed surprise at the high standard of health care facilities in the city: "I think it is crucial to see how beautiful, clean, and well-apportioned even the community health centers – places where people with 'no insurance' go to get care – are under the Canadian system" said one. After visiting the Hospital for Sick Children, another participant declared it was "beautiful, and

dispelled any lingering doubts I had about the ability of a single-payer system to adequately fund hospitals".

The Canadian visit came on the heels of an intensive one-day study session in Buffalo, N.Y., on U.S. health care policy and structure, leaving the group primed for comparison of the two countries' health systems. They were, as a group, impressed with the Canadian model of care. In the words of one student: "I was surprised by how well accepted [the health system] is by Canadians – I mean all we ever hear about are the long waits, yet the people are really proud of the fact that they all get health care".

After four days of intensive studies in comparative health policy, the group was exhausted, but energized to apply their

knowledge to health policy reform in the U.S. From a rather vague understanding of Canadian health care provision, they left with a sense of the complexities, struggles, challenges, and successes of our health care system. They left with the knowledge that a single payer model is not "experimental" here, but functions in a real setting to provide Canadians with excellent health care.

For this Canadian host (and health care provider), it was encouraging to see outsiders to our system of care so impressed with how it functions in reality. While a vocal group within our health care system continue to express envy of the American model of care, it was heartening to hear Americans express enthusiastic support for a universal and equitable approach to health care. ♦

CANADA'S DRUG REGULATORS-- WORKING FOR YOU, OR FOR THE INDUSTRY?

You meet Paul Stolley, and you find a gentle, soft-spoken, older man with a delightful sense of humour. A perfect grandfather, or everyone's favourite uncle.

Yet, Stolley is one of the harshest critics of the U.S. Food and Drug Administration (FDA). The FDA decides whether there is enough evidence of benefit for drugs to go on the market, or enough evidence of harm to keep them off.

Stolley's complaint? Since 1992, the American government has required drug companies to pay a big part of the cost of the drug regulation process. Companies now pay almost half the FDA's cost of reviewing drugs.

Stolley believes that the funding situation has made the FDA the industry's servant. "I think it's a shame how it has fallen

down on the job. The FDA is in partnership with industry. It should be negotiating, not in partnership. Why is it in partnership? Because it's financially supported by industry."

What has led Stolley to his harsh conclusion? Stolley had an outstanding career as a health researcher. His credits include 8 years as Chair of the Department Preventative Medicine in Maryland, and a term as President of the American Epidemiological Society. In July 2000, he joined the FDA as a senior consultant.

Stolley's first job was to check out a recently approved drug called alosetron. A giant company, GlaxoSmithKline, markets the drug for "irritable bowel syndrome" or IBS. People with IBS suffer from on-and-off diarrhoea, constipation, and abdominal pain. The

condition is common. Depending on the definition, up to 20 per cent of the population suffer from IBS. Most IBS is mild, a nuisance more than an illness. Not the sort of condition that warrants a drug with serious side effects.

In February 2000, the FDA approved alosetron for treatment of women with IBS who have diarrhoea as their main symptom. Several trials suggested that Alosetron helps this subgroup of patients. But the effect was modest. About 40 per cent of the women taking placebo (a "sugar pill") improved. An additional 20 per cent improved with alosetron.

Stolley was assigned to look at the drug because of alarming reports of side effects. These included severe constipation leading to a leak in the bowel, and "ischemic colitis" or severe bowel

(continued on page 11)

CANADA'S DRUG REGULATORS-- WORKING FOR YOU, OR FOR THE INDUSTRY? (continued)

inflammation. Stolley raised a warning cry, and in November 2001, the company agreed to withdraw the drug from the market.

Almost immediately, however, the company lobbied for re-marketing the drug with restrictions. Stolley's boss at the FDA criticized Stolley for being too negative about alosetron, and told him it should be back on the market.

Feeling shut out of discussions, Stolley left the FDA six months ahead of schedule. By April of 2002, serious complications of alosetron had led to 100 hospitalisations, 50 surgeries, and 7 deaths. An FDA committee of experts suggested that alosetron be put back on the market, but with severe restrictions. The FDA decided to put the drug back on the market, but without the restrictions the committee had recommended. One member of the committee, Dr. Brian Strom, one of the world's leading experts on drug use, thinks the FDA made a bad decision. "With alosetron, the risk-benefit ratio is not worth it," Strom has said, "unless the use can be restricted to those who really need it and who are likely to benefit from it which is a very, very small group." Should Canadians care about this worrisome situation? Like the U.S., since the mid-1990s the Canadian government has been charging industry to pay for the drug regulation and approval process. Critics of the Therapeutic Products Directorate (TPD), Canada's FDA-equivalent, believe that the funding change has led to a similar inappropriate partnership between the drug manufacturers and the drug regulators here in Canada.

Critics point to an internal bulletin issued by a senior TPD official, Dann Michols, in 1997. Discussing whom the TPD should serve, Michols advised staff "the client is the direct recipient of your

services. In many cases this is the person or company who pays for the service." The document gives the public secondary status of "stakeholder" or "beneficiary". Is there any evidence that TPD is putting industry interests ahead of the public? The TPD's attitude to direct-to-consumer (DTC) drug advertising suggests the answer is yes.

In an earlier column, I described how DTC advertising leads to more inappropriate prescribing, and escalation of skyrocketing drug spending. In Canada, as in almost all industrialized countries, DTC advertising is illegal.

TPD has become very lax in enforcing the ban, allowing advertisements that clearly violate the law. Worse yet, TPD is seriously considering following the U.S. lead and allowing DTC advertising.

Roy Romanow's report recognizes the problem of TPD's conflict of interest. "In effect," Romanow said, "a 'firewall' must be established between the industry's financial contribution and the Agency's work. Very stringent guidelines for pharmaceutical industry contributions should be in place to ensure the Agency's independence from the industry it regulates."

Whoever pays the piper calls the tune. Should our drug regulators be putting the industry's needs above the public's health? Not on your life — or death. ♦

First published as one of Dr. Gordon Guyatt's biweekly columns in the Hamilton Spectator February 21, 2003.

WANT TO RUN A FOR- PROFIT MRI: DONATE TO PROVINCIAL TORIES

The Medical Reform Group has accused Ontario's provincial government of selling out Ontario citizens to pad their campaign coffers. The government has announced the companies that will run four investor-owned for-profit community diagnostic facilities offering MRI and CT services. Two have donated substantial funds to the provincial Conservative party.

"There are a number of reasons why investor-owned for-profit clinics are bad news for the people of Ontario," said MRG spokesperson Dr. Gordon Guyatt. "First, they open the door to two-tier access to scarce diagnostic services."

This government has declared that only those who do not need the services can buy themselves to the front of the line. "If clinics adhere to the government rules, it means that people wanting scans for unproven indications, like 'yuppie' screening for cancer, will get the procedure first," said another MRG spokesperson, Dr. PJ Devereaux. People who really need it will wait longer. But they probably won't stick to the rules. Either way, it means that those who can't pay will stay at the back of the line."

Another problem is that the for-profit clinics will suck scarce radiologists and technicians from hospital MRI and CT facilities. Opposition to yuppie scans, to two-tiered care, and to bleeding the hospitals has led the Ontario Association of Radiologists to strongly oppose the for-profit clinics. Finally, evidence from the US suggests that diverting money from patient care to profit decreases quality of care, and can increase death rates.

"All rational arguments indicate that these facilities should operate on a not-for-profit basis," Dr. Guyatt concluded. "But to our government, the company money speaks louder." ♦

Released by the Medical Reform Group February 24, 2003.

FEDERAL GOVERNMENT SHOWING THE RIGHT STUFF

Prime Minister Jean Chretien and Health Minister Ann McLellan are demonstrating both courage and wisdom in their determination to implement many of the Romanow Commission's recommendations, the Medical Reform Group said today.

"The federal government has set goals of adding home care to the Canada Health Act, funding uniform access to catastrophic drug coverage, aggressive targets for implementation of primary care reform, and a national health care advisory body to make sure it all happens," said MRG spokesperson Dr. Rosana Pellizzari. "These are all key Romanow recommendations."

The MRG believes that the federal government is right to insist on provincial accountability to the federal government for the large transfers it makes to the provinces.

"In the past, the provinces have in effect used federal money intended for health purposes to fund tax cuts," said another MRG spokesperson, Dr. Ahmed Bayoumi. "Romanow and Kirby both insisted that the federal government use its money to buy change. It appears that Ann McLellan is heeding this sound advice."

The federal government may face a battle with the provinces, which want all the federal money with no strings attached. It is clear that some provinces, Ontario for instance, would like to continue their prior practice of using federal transfers to fund tax cuts.

"We strongly encourage Jean Chretien to hang tough in his negotiations with the Premiers," said Dr. Bayoumi. "The federal government has the money, and the popularity of Romanow's wise recommendations, to bolster its bargaining position. There is no reason to back down on any of the key issues."

"The federal government's current stance is the strongest, and the smartest, they have taken for years," Dr. Pellizzari concluded. "If they stick to their guns, all the effort that went in to the Romanow and Kirby reports will prove well worth it." ♦

Released by the Medical Reform Group January 31, 2003.

TEXT OF LETTER

January 31, 2003.

Rt. Hon. Jean Chrétien
Office of the Prime Minister
80 Wellington Street
Ottawa K1A 0A2

Prime Minister:

The Medical Reform Group wishes to congratulate you, and your Health Minister, the Hon. Ann McLellan, for demonstrating both courage and wisdom in pressing forward with the implementation of Romanow Commission recommendations.

We are encouraged that you have set as goals the addition of home care to the Canada Health Act, funding uniform

access to catastrophic drug coverage, aggressive targets for the implementation of primary care reform, and a national health care advisory body to make sure it all happens. These are all key Romanow recommendations.

The MRG believes that you and your government are right to insist on provincial accountability for the large increases in transfers to the provinces that you are planning. In the past, the provinces have in effect used federal money intended for health purposes to fund tax cuts. Romanow and Kirby both insisted that you use federal money to 'buy change.' We commend you and your minister for heeding this sound advice.

We are very aware that you may face a battle with the provinces, which want all the money but with no strings attached. Indeed, it is clear that some provinces, Ontario for instance, would like to continue their prior practice of using federal transfers to fund tax cuts. We urge you to be steadfast in the coming negotiations with the Premiers. You have the great advantage of the popularity of Romanow's wise recommendations to bolster your bargaining position. There is no reason you need to back down on any of the key issues.

Once again, we convey our admiration and congratulations to you and the Hon. Ann McLellan. ♦

PRINCIPLES AND POLICY STATEMENTS OF THE MEDICAL REFORM GROUP

The Medical Reform Group believes that our profession must look to the social, political, and economic forces shaping health and health care in Canada today.

As we have been posting material from our archives to the Internet, we have been reviewing the content of some of our main policy items for continuing relevance and applicability. Over the winter of 2003, the Steering Committee has revised several of our founding documents to reflect our continuing vision and principles. Included in this issue are the results of that review, with the expectation that members will respond to the Newsletter Editor with a comment on any items they think should/should not be changed. In the absence of substantial disagreement with the proposed changes in the preamble, principles and the policy statements on the Definition of Insured Services, Health Resources Allocation and the Necessity for a Strong Federal Role in Setting Canadian Health Policy, which are reflected in the following version, they will be deemed to replace the originals as of the Fall 2003 Members Meeting.

Preamble

Canadian health care is subject to an ongoing struggle between advocates of public funding and not-for-profit delivery versus private funding and for-profit delivery

Our values dictate public funding for health services; evidence tells us that public funding is more efficient, as well as more equitable, and that not-for-profit delivery offers higher quality care. Science tells us that the roots of the common causes of illness in Canada lie at least partially in correctable social, economic, occupational and environmental conditions. Because we believed that current organizations do not adequately represent these views, we formed the Medical Reform Group in 1979, as a voice for socially concerned physicians. We are, by constitution, independent of any political party or

organization, and similarly, independent of any other professional organizations.

Principles

The Medical Reform Group is a democratic organization dedicated to the following 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 deterrent to equal care.
- **Health is, in part, 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 important contribution of all health care workers is 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.

Policy Statement on the Definition of Insured Services

Up to now, we have not had a clear definition of the insured health services that provincial governments are mandated to provide to the public. Legislation stipulates that these services be comprehensive, but compre-

hensiveness is subject to wide interpretation. The result is there is appreciable heterogeneity in the services covered by the various provincial health plans.

Recently, observers of the Canadian health care system have suggested that it is time to more precisely define insured services. Sources of pressure have included members of the legal community, and voices warning us that, in the face of budget restraints, we can't maintain the current level of public health care. The focus of the definition of insured services is on "medical necessity" — the notion being that only medically necessary services should be covered.

Intuitively, the precise definition of insured services makes some sense. Public values define what is appropriate coverage, and we establish uniformity across provinces. We reduce the burden on public spending by eliminating inappropriate services from the domain of the insured. Potentially, this allows us to continue with universal coverage for the services that are really important. There are, however, a number of major problems with this approach.

First, it equates comprehensive coverage with medical necessity. The two are very different. Many health services, including for instance dental care, are necessary for maintenance of health, but well not be considered "medically necessary". Limiting exposure to environmental pollutants is necessary for maintenance of health, but is even farther from some peoples' notion of medical necessity.

Second, even if one accepts the limited scope of medical necessity, the process of considering specific services makes evident the difficulties of defining the correct range of insured benefits. While

(continued on page 14)

PRINCIPLES AND POLICY STATEMENTS OF THE MEDICAL REFORM GROUP (continued)

there are many services about which one can raise questions on the basis of public versus individual responsibility (tattoo removal, for instance), one can almost invariably think of instances in which one would want these services covered. While one can raise questions about the effectiveness of services (intensive psychotherapy, for instance) considering both the caring and curing functions of medicine gives one pause.

The MRG has found that discussions of the exact range of appropriate insured services quickly show that satisfactory resolution is impossible.

This makes us question the need for a precise definition of insured services. The Canadian health care system worked well for 25 years without such a definition. Provincial governments have maintained acceptable coverage, and there are few, if any, gross violations of the principle of comprehensiveness. Should there be such violations, the federal government is in a position to withhold funds from the offending provinces. So why the current debate?

The debate is a function of the budgetary pressures on governments. The cost-cutters see restricting the range of insured services as a way of trimming the system. As it turns out, when one looks at what we will save by de-insuring the controversial procedures, the amount is trivial. To really reduce public expenditure would require removing a wide range of services. We believe the push for a definition of insured services is another feature of the systematic attempts to undercut our universal public health care system.

With respect to definition of insured services, the system isn't broken, and doesn't need to be fixed. The solution to the problems of cost pressures on the system include improving efficiency in health care, and revising our priorities on the mix of public and private resource allocation within our society. Canada's

current rationing strategy, limiting resource availability (hospital beds, high technology equipment, the number of health care providers) and letting health care providers work out the most efficient way of using the resources available, continues to be the most appropriate. At the same time, we acknowledge that advances in medical knowledge and technology require adequate resources to deliver.

Our answer to the precise definition of necessary services is that we don't need such a definition. If pressed further, we believe that we should not consider only what is medically necessary, but rather the notion of comprehensive care required to maintain and enhance health. Under this framework, we would use the broadest definition of insurable services, including areas on the border of health care that nevertheless have an important impact on health. The health care community should, for instance, be involved in ensuring optimal environmental standards. Our bottom line is that the debate concerning what is necessary medical care ultimately distracts us from dealing with the real issues in health care delivery today.

Policy Statement on Health Resource Allocation

We believe our position should be based on the following four principles which we found very useful as a conceptual framework. These principles are presented in their order of importance:

- ***Equity*** - Access to health resources should be determined based on need, as determined from a broad perspective on health that takes into account physical, psychological, and social wellbeing. The goal of health resource allocation should be to

correct inequities between individuals and groups in these three areas.

- ***Societal Perspective***-Taking a societal perspective has two major implications. First, that the roots of some ill health can be found in political, economic, and social policies and situations. Therefore, health may be improved more by spending money to correct the roots of ill health (and thus spent outside of the health care system) than by spending within the system. Second, spending on health care should be examined within the context of total societal resource allocation. For instance, we should see health spending as a proportion of GDP, and in relation to expenditures on the military, or luxury consumer goods.

- ***Effectiveness***-Health care diagnostic and therapeutic technologies should be supported only if they have been shown to improve outcome (i.e. the length and/or quality of life). The burden of proof to establish this benefit should be on those lobbying for the acquisition or dissemination of expensive technologies.

Consideration of quality of life outcomes implies a "humanist" perspective that may outweigh considerations of "cost-effectiveness" (when effectiveness is narrowly defined). An example would be allocation of health care resources to the elderly.

- ***Efficiency***-The efficient distribution of resources (maximizing cost-effectiveness) within the health care system should be one goal of the system. This was seen as very definitely the bottom of the list in terms of the four principles.

In the final part of the discussion, we provide examples of how these principles could be brought to bear on

(continued on page 15)

PRINCIPLES AND POLICY STATEMENTS OF THE MEDICAL REFORM GROUP (continued)

the current issues regarding health care delivery in Ontario.

- **Equity**-We would continue to oppose any proposal, like user fees, which would compromise equity. We would support proposals, like selective allocation of resources to the economically disadvantaged (for instance, improved access to public housing), or to the socially or physically disadvantaged, that would improve equity.

- **Societal Perspective**-In general, we would lobby for allocation of resources in ways that would improve health outcomes, and against allocation of resources in ways that would have adverse health consequences. This would be true both in and outside of the health care delivery system.

There are a number of specific areas in which the MRG could lobby on the basis of the health consequences of societal decisions regarding resource allocation. Examples include the following:

- Support for the tobacco farmers: we might support allocation of funds for switching over from growing tobacco to other crops.
- Social programs which would improve health: we might support programs which would deal more effectively with homelessness, and with domestic violence and its consequences. We could suggest that the health costs of unemployment be factored in when the decisions concerning employment subsidies, job creation schemes, and the like are considered.
- Road traffic accidents: we might support changes in the transport policy that would decrease the number of civilian casualties in highway wars.
- Alcohol: we might support policies that would decrease alcohol consumption, and the consequent deleterious health effects.

- Occupational health: we might emphasize stands we have already taken in support of a safer work place.

- Nutrition: we might support policies that would encourage the production and consumption of healthier foods.

Conceivably, we might prepare a yearly commentary on the provincial budget from the point of view of its impact on the health of the people of Ontario, in terms of issues such as those raised above.

- **Effectiveness**-We could speak against allocation of resources to any new technology in which evidence of improved outcome was not available. This would clearly mean knowledge of the evidence regarding the issue about which we spoke.

- **Efficiency**- There will be instances in which the MRG will want to speak in favour of efficient allocation of health care resources. One might be expenditure on the development of new pharmaceutical agents which achieve little incremental advantage over existing agents (so-called "me too" drugs). Another might be expenditures on sophisticated imaging technologies in which effect on health outcomes is likely to be minimal. Whenever such statements are made, we feel that it is crucial to emphasize the areas to which the money saved should be allocated. Such areas might include:

- home care for the elderly (despite its cost-ineffectiveness)
- palliative care
- shelter for battered wives
- social, environmental, and nutritional intervention in pre-natal care
- occupational health
- family planning clinics
- mammographic screening in 50 to 60 year old women
- dental care

- care for the chronically psychiatrically ill
- chronic care facilities for the handicapped

We believe issues of resource allocation will determine the future of health care in Ontario. The MRG must take part in what is certain to be a heated debate. Clearly, we hope the membership will in general endorse the principles we have outlined. Most certainly, we hope these principles will be given thought and consideration, and useful alternatives or modifications will be raised.

Statement on the Necessity for a Strong Federal Role in Setting Canadian Health Policy

We believe that the issue of whether the federal government should be involved in setting and maintaining standards for delivery of social services is fundamentally an issue about the model of society we want for Canada. Within health care, it is a debate about whether we want to maintain a universal single-payer model, or whether we want to move to a privatized, U.S.-style mixed model, with much more payment by the health-care users. Evidence suggests that those who claim otherwise are either disingenuous or misguided.

We shall cite three lines of evidence to substantiate our viewpoint. One is historical, the second examines the political orientation of those advocating reducing or eliminating the federal role in maintaining standards, and the third has to do with the nature of the federal role.

In the early 1960's Canada had a mixed private-public system of health care, with a prominent role of user fees and financial disincentives for care. The universal, single-payer system was solely

PRINCIPLES AND POLICY STATEMENTS OF THE MEDICAL REFORM GROUP (continued)

a federal initiative. Indeed, many provinces resisted the move to the single payer system. They adopted the system only because the federal incentive (at that time, paying 50 per cent of the cost of services) was too attractive.

A compelling testimony to the provincial resistance is a comment made by John Robarts, then Ontario premier, about the federal governments' plan for national health insurance covering all physician and hospital services. "Medicare is a glowing example of a Machiavellian scheme that is in my humble opinion one of the greatest political frauds that has been perpetrated on the people of this country." This 'fraud' has turned out to be our most successful and popular social program, contributing in important ways to both Canadians' health, and their sense of self-definition.

With the rapidly growing economy of the 1960's and early 1970's the new universal single-payer system worked very well. As the economy slowed down and increases in physician reimbursement schedules decreased, tensions emerged. Physicians across the country began to increase their extra charges to patients beyond what health insurance would reimburse. Provincial governments increased user charges for other services. The fundamental goal of the program, equal access without financial disincentive, was threatened.

The federal government, once again on its own, responded to this threat. Over some provincial objections, Ottawa introduced the Canada Health Act. As with the initial introduction of Medicare, the federal government could not decree compliance with its principles. It could, however, penalize provinces that allowed user fees for insured services by reducing transfer payments.

The effect of the Canada Health Act has been profound. It has presented a formidable barrier against the backsliding

in health delivery which was occurring at an accelerating pace, and which appeared destined to end the era of equal access to high quality health care without financial deterrents. Each of the provinces enacted legislation ending physicians' opting-out and extra-billing, and universality has been preserved.

Since the mid-1980s the provinces have periodically challenged the federal resolve to enforce the Canada Health Act. Prior to the recent federal decision to once again penalize provinces, user fees were growing, particularly in Alberta and British Columbia. It is clear that without federal action, the trend would have continued.

Historically, then, we see that universal health care would never have been instituted had it not been for the federal initiative, and would have been destroyed had it not been for strong federal action that has led to its maintenance.

The second consideration has to do with the political orientation of those advocating ending Ottawa's role in maintenance of social standards. The Klein government has been the most aggressive in pursuing user fees, and their enthusiasm for making the sick patient pay lead to a confrontation with the federal government. There is little doubt where these governments would lead their provinces with the freedom that would follow from an end to federal standards.

Finally, we note that federal intervention has been uni-directional. No federal government has ever prevented provinces from extending covered services (such as to dental care or pharmaceuticals); the interventions are all related to attempts to dismantle universal, single-payer care. Provinces wanting to strengthen health-care need not worry about restrictions from the federal government.

In health care, the debate over federal standards is a debate over universality, and should be treated as such. The Canadian public should know this. Our current health care system suffers from the financial pressures facing every health delivery system in the world. Nevertheless, we have achieved and so far maintained a system that has achieved, to an extraordinary degree, its goals of universal, high-quality care. Canadians strongly support Medicare. If we are to maintain this system, continued federal power in setting standards, and federal resolve to enforce those standards, remain a necessity. ♦

WHY LEAVE THE MRG? and WHY RE-JOIN THE MRG?

Hareesh Kirpalani

Medical Reform Group policy formulation is generally an exciting, but not terribly controversial process. On most of the current critical issues, we are of similar mind. On occasion, this is not so, and the debates are contentious. The following is personal reflection of an MRG member on issues that he considers critical, and on which he feels the MRG has let him down. We encourage such critical reflections. From our point of view, the more the active debate in the group, the better. Responses, or parallel discussions expressing your own particular perspectives, would be more than welcome.

I was recently shamed by a very good friend who asked me “Why was a former editor of the newsletter for the “Medical Reform Group”, no longer paying dues as a member?”

This was put to me by someone whose commitment to the progressives causes of the world at large, was totally beyond question. So I was forced to take this seriously. I had only one reason to leave the MRG in fact – I had lost my faith in the legitimate credentials to the term “progressive” - of an organisation that ducked out – on some very critical issues. What were those issues I perceived that the MRG had “ducked out on”? How valid in any case, was my ‘loss of faith’? The issues were (and I suspect still are): A lack of appropriate critical distance from the New Democratic Party (NDP); and, a lack of appropriate critical distance from imperialist organisations, actions and supporters. Let me first try to explain my point of view. We can then at the end assess how “valid” these perceptions or concerns might be.

Firstly a lack of an “appropriate critical distance from the New Democratic Party (NDP)”. I recall a bitter fight for a perspective within the MRG, over cut-backs. A benign view had it that cut-backs in health care were the actions of a ministry anxious to effect evidence based medicine and public health. A more malignant view held that this was capitalist cost-cutting - period.

That was a difficult struggle within the MRG, and it is certainly true that during it, I personally may have been somewhat strident. I do apologise if that was the case. Nonetheless, perhaps a certain degree of stridency was called-for in the

face of some astonishing short-sightedness.

Irrespective of the conduct of this ideological battle, it seems that the bulk of the MRG membership did accept a view that the cut-backs were iniquitous and unacceptable. Masked as the cut-backs were, by a cloak of “rationalization” – this was a difficult but important step.

Yet even when this step was taken, the ethos of the MRG members remained only to challenge the source of these cut-backs, if they emanated from the Tory or Liberal parties. Sadly, the reality that these cut-backs in Ontario were being perpetrated by a social-reformist NDP government – using its “progressive” camouflage – was simply ignored. It was too inconvenient. This attitude I found limited my view of the MRG as being “progressive”.

Secondly, “a lack of appropriate critical distance from imperialist organisations, actions and supporters”. I am sure many of you might be astonished at this assertion. However, clear blocks to saying anything about some international actions and violations of human moral codes – were given. They usually (?always) involved the state of Israel.

It is astonishing that an organisation that considers itself as being for the well-being of peoples, has not – for instance come out with a condemnation of the last 12 years of Iraqi sanctions; and worse – does not attack the abominations of what is happening in Iraq? Why not? By the way, I would suggest that it not be charged that I am a supporter of Saddam Hussein. I trust the MRG members who do not support an open

condemnation of USA and UK imperialism in these actions, will not accuse me of that. It is interesting that on this matter – the NDP have adopted an open condemnation. And yet – the MRG has not.

Well – so much for my perceptions. How valid are these?

Firstly, one should concede that the MRG continues to be the only game in town for those calling themselves progressives docs.

Secondly, I concede that this is a United Front – confined to one aspect in essence, the defence of universal publicly funded health care. In this regard undoubtedly the vanguard of the MRG has done some amazingly sterling work, led by P.J. Devereaux and G. Guyatt. It is impossible to ignore that. But is that enough?

Thirdly, I will accept that unless one is in the mud pulling the cart across the plains, that critiques from a distant cosy library – are worse than unacceptable.

So – I would have to conclude that the time has come to get back into the mud. But I did think that an open explanation of my own perceptions was necessary. Those of you who disagree – should come out and throw some mud back! ♦

TORIES TARGET HOSPITAL AUDITS, IGNORE THEIR OWN

Tony Clement has a great idea. The Ontario health minister is suggesting that Erik Peters, the provincial auditor, receive a widened mandate.

Ontario's Ministries spend half of the provincial budget directly. The other half goes to fund private not-for-profit institutions like hospitals and universities. The provincial auditor gets to check the books only for the direct part of the spending.

Our hospitals are not publicly owned and managed. Because they belong to their hospital boards and communities, or religious institutions like the Sisters of St. Joseph's, hospitals are out-of-bounds to the auditor. Mr. Clement wants to change that.

On January 13, 2003, the Minister suggested that the auditor should check hospital budgets to seek out waste, and to ensure hospitals spend money on the programs the government intended.

Mr. Clement chose an interesting venue for his suggestion.

For years, governments and hospitals have engaged in an elaborate dance around hospital budgets. First, the government doesn't give hospitals enough. The hospitals cry foul, often with lots of publicity. Later, the government backs down, and gives the hospitals some of the extra money they are demanding.

This year, the extra money amounts to \$350 million. Mr. Clement raised the possibility of widening the provincial auditor's mandate during a press conference announcing the team that will review hospital applications for the extra \$350 million.

Hospitals claim that not knowing how much money they will have to spend until late in their fiscal year prevents intelligent planning. They are right.

Well, so what if Mr. Clement made his announcement in a context that reflects his government's not-so-smart business practices? Having the auditor check the

hospital books is still a wise move, isn't it? Maybe not.

Mr. Peters, the auditor, has been calling for widening his powers for a decade. If it's such a good idea, why has the government resisted for so long?

Perhaps because the audit will be a waste of money. Hospital administrators already face a rigorous yearly audit supervised by their hospital boards. David MacKinnon, Ontario Hospital Association President, believes that an additional audit would not uncover significant problems, and would generate substantial additional administrative costs.

Thinking about his own institution, St. Joseph's Hospital CEO Kevin Smith believes there are better ways of spending resources than an additional audit. "I'd rather spend the money on patient care." If MacKinnon and Smith are right, why is the Tory government pushing the additional audit?

In an editorial otherwise supportive of the move, the *Spectator's* questioned Clement's motives. The *Spectator* suspects that the government supports the new audit not because of a commitment to accountability, but to strengthen its hand in negotiations with hospitals. If Peters finds problems, Clement can claim that it's not underfunding that's causing budget difficulties, but misuse or inefficiency.

The government's own record in provincial audits sheds light on whether the *Spectator's* guess is correct. Consider examples from the last audit.

First example: In the mid-90s, the Ministry of Community, Family & Children's Services realized that its computer system for social assistance payments needed an overhaul. It hired a private company, Accenture, to do the job.

Accenture's system has serious flaws. Many service managers think the new system is inferior to the previous one. It has resulted in unexplained errors, including about 7,000 payments totalling \$1.2 million to ineligible individuals.

Despite the failed system, and contrary to the recommendations of the Provincial Auditor and the Standing Committee on Public Accounts, the Ministry paid Accenture \$66 million outside the original \$180-million payment cap.

Second example: The government has not addressed issues in the delivery of mental health identified by auditors in reports over 15 years. The Ministry doesn't have information needed to assess whether we are caring adequately for mentally ill people, and whether mental health dollars are being prudently spent.

The Ministry doesn't know the number of people receiving or waiting for community mental health services or the waiting times to access services. Annual per person funding in the seven regions of the province ranges from \$11 to \$60, but the Ministry has not looked at whether the variation means different levels of service.

Third example: Annual spending on consultants under the Tories jumped from \$271 million in 1998 to \$662 million last year. Peters cited a litany of cases that suggest taxpayers are not getting good value for their money.

In one case, 40 employees of the Public Safety Ministry left their jobs and were rehired as consultants within days at more than double their salaries. The government allowed one consultant's daily fee to rise from \$725 in April 2000 to \$2,600 within six months, and hired a consultant who owed \$110,000 in back taxes.

Will a provincial audit of hospitals lead to more efficient hospitals, or simply waste resources that hospitals should be spending on patient care? The government's failure to act on what the auditor says about its own internal spending raises serious doubts about its motivation for an additional hospital audit. ♦

First published as one of Dr. Gordon Guyatt's biweekly columns in the Hamilton Spectator March 7, 2003.

STOP PRESS

The April 5 Caravan of Protest Against the For-Profit Hospitals and MRI/CT clinics has been moved to Saturday, May 10 due to concerns regarding the SARS outbreak.

Thousands of hospital workers, radiation technologists, physicians, seniors, families will join cavalcades travelling across Ontario to stop the plans for the creation of the first for-profit hospitals in this province since Medicare's inception.

The Toronto event is being rescheduled as follows: Saturday, May 10th at 2.30 pm, cavalcades will converge in Toronto to join a march starting at Front and Bay Streets.

For more information on local campaigns, call the Ontario Health Coalition at [416] 441-2502 or check their website at www.ontariohealthcoalition.ca. ♦

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MAKING CHANGE: ACTIVISM AND ADVOCACY IN MEDICINE

Panelists:

Philip Berger, Chief, Family & Community Medicine, St Michael's Hospital

Danielle Martin, President, Canadian Federation of Medical Students

Gary Bloch, Resident in Family Medicine, St Michael's Hospital

MEDICAL REFORM GROUP SPRING MEMBERS MEETING

Wednesday, April 30, 2003, 6.30 PM
*Room 2172, Medical Sciences Building,
1 King's College Circle, Toronto*

FREE

FOR MORE INFORMATION: *Medical Reform Group--(mrg@web.ca; [416] 787-5246)*

**Medical Reform Group
Box 40074
RPO Marlee
Toronto, Ontario
M6B 4K4**

*Please visit and comment on our web-site
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