

# MEDICAL REFORM

## Newsletter of the Medical Reform Group

Issue 127

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## CAN AN ONTARIO ELECTION BE GOOD FOR OUR HEALTH?

*Rosana Pellizzari*

Ontario's Tobacco Control Act, proclaimed in 1994 to make sales to minors illegal, eliminate the sale of tobacco in pharmacies and vending machines, and restrict smoking in certain public places, is long overdue for an overhaul.

According to an expert panel report submitted to then-Minister of Health Elizabeth Witmer in 1999, necessary amendments to both the Tobacco Control Act and the Smoking in the Workplace Act have not been made, allowing considerable exposure to environmental tobacco smoke in workplaces and public places to continue.

During their time in government, the Tories have slashed budget allocation for tobacco control to \$1.70 per capita, an amount representing only one tenth of the level recommended for comprehensive and effective tobacco control programmes by the US Centres for Disease Control. Ontario's low price for tobacco products makes it easy for all smokers, especially price-sensitive youth, to purchase cigarettes.

Left to wander in the wilderness, Boards of Health had had both successes and failures in acquiring municipal or regional government support for smoke free bylaws. Some, like Athens Township in Leeds and Grenville County, have passed by-laws allowing proprietors to choose whether to maintain a smoke-free environment. Others, like communities in north-

western Ontario, have struck down by-laws. Clearly, it's time for a change and perhaps an election, and a change in government, is what it will take.

An OMA position paper published in February 2003's Ontario Medical Review has called for a 100% ban on environmental tobacco smoke in all Ontario workplaces and public places. The superb paper begins with the statement

"The overwhelming body of medical evidence contained in hundreds of scientific studies and six internationally recognized comprehensive reviews undertaken during the last decade, clearly demonstrates the direct causes and linkages between exposure to

second-hand smoke and serious health effects among non-smokers,"

and ends with four recommendations aimed at government.

In addition, the paper includes proposed amendments to Ontario's Tobacco Control Act: amendments which would repeal the weak Smoking in the Workplace Act, expand the ban to all workplaces and well-defined "public" places, and incorporate whistle-blowing protection into the act.

That is exactly the right prescription for legislative change in Ontario to protect all our workers and citizens from the single largest cause of preventable premature mortality in Canada. Tobacco continues to kill about 12,000 Ontarians each year, a number that accounts for one in six deaths.

In the meantime, Ontario's Tobacco Control Act has allowed the tobacco industry to influence local politics and intimidate Boards of Health into passing weak by-laws which either allow unenclosed smoking in certain workplaces and public places, mandate designated smoking rooms, or DSRs which do not protect workers and have never been proven to completely eliminate the exposure risk to the over 4,000 chemicals in tobacco smoke, or contain sunset clauses extending as far into the future as never, or as in the Region of Peel's new bylaw, not until 2010.

*(continued on page 2)*

### INSIDE

Public Health.....	4
CHA on Trial.....	4-6
National Health Council.....	7-9
Guyatt Columns.....	10-11, 14, 17
Boutique Medicine.....	12-13
P3s.....	13-15
Medical Necessity.....	16-17
PNHP releases.....	18-19
MRG Principles.....	20-21
Steering Committee.....	21-23

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## 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>.

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

**Editorial committee this issue:** Rosana Pellizzari, 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.

# CAN AN ONTARIO ELECTION BE GOOD? (continued)

In a study examining 25 instances in which the tobacco industry opposed health board regulation in the U.S.A., researchers identified three main strategies: "accommodation" (tobacco industry public relations campaign to accommodate smokers in public places), legislative intervention, and litigation.

Published in the American Journal of Public Health in 2002, authors Joanna Dearlove and Stanton Glantz found that these strategies were often executed with the help of tobacco industry front groups or allies in the hospitality industry. This has certainly been the case in Ontario.

When the City of Toronto attempted to pass its first smoking by-law in 1996, executives of the Ontario Restaurant Association (ORA) worked closely with the Canadian Tobacco Manufacturer's Council to fund the fight against the by-law. They were successful in having the by-law fail a mere two months after its introduction. During the introduction of the second by-law in 1999, the ORA retained tobacco industry consultant John Luik to speak at its May 1999 press conference.

The CBC "Fifth Estate" television program later exposed Luik as an academic fraud. The OMA position paper alleges that The Pub and Bar Coalition of Ontario, PUBCO, one of Toronto's Board of Health most vocal anti-by-law opponents, also receives support from the tobacco industry.

The recent by-law introduced in the Region of Niagara serves as another example of why Ontario needs provincial legislation reform to secure smoke free workplaces for all workers. Niagara introduced its by-law on May 30, 2003. All bars and restaurants are required to be smoke-free, but designated smoking rooms are allowed. The by-law does not specify if these will be sunsetted eventually, although public health staff is advising proprietors that

that the DSRs are not guaranteed in perpetuity.

What really irks Niagara bar and restaurant owners is that the Niagara Casino, the second largest employer in the region, has been exempted. Casino owners, who grossed almost \$600 million in revenues in 2000-01, lobbied to have the exemption on the grounds that, just across the Niagara River, the competing American casino allows smoking. Although Niagara Falls, New York has smoke free bylaws, their casino is exempt because it sits on aboriginal land. Or, to be more accurate, land that was given to First Nations people by the city so that a casino would be exempt from municipal by-laws!

Niagara bar owners have organized to oppose the new bylaw and, according to the Canadian Chapter of FORCES, an "international smokers' rights movement", have recruited two local bar owners, Jim Henley and Gail Tomori, to run for City Council in the upcoming municipal elections in November. FORCES also calls for Canadians to throw the federal Liberal "Parasites" out of office in order to stop the attack on smokers.

In Peel, home to the ridings of both Health Minister Tony Clements and Premier Ernie Eves, just west of Toronto, the newly proposed regional smoke-free bylaw excludes two workplaces in Brampton: the Daimler Chrysler plant and, no surprises here, Rothmans, Benson and Hedges, cigarette producers whose Canadian earnings in 2000 amounted to \$205 million in pre-tax profits. Despite recommendations from its Medical Officer of Health, Dr David McKeown, to sunset DSRs in 2008, Peel Regional Council chose 2010 instead, conceding to pressures brought to bear from small business owners and bingo operators.

(continued on page 3)

# CAN AN ONTARIO ELECTION BE GOOD FOR OUR HEALTH? (continued)

This is in spite of the fact that the economic impact of smoke free by-laws on the entertainment and hospitality industry is relatively neutral, although the myth being perpetuated by the bar industry, and fuelled by the tobacco industry, is that smoke free bylaws are bad for business. On the contrary, both American and Canadian research consistently has shown that restrictive legislation has no significant effect on sales.

The battle being waged in Northwestern Ontario by Medical Officer of Health Dr Peter Sarsfield will determine whether Ontario's Health Protection and Promotion Act (HPPA) gives public health officials authority to close down smoky workplaces and public places on the grounds that second hand smoke poses a health hazard to those exposed. Frustrated with inaction, Dr Sarsfield used Section 13 of the HPPA to order owners of public places to prohibit smoking in their establishments.

The orders are being appealed, with hearings scheduled in late September. The outcome of the hearings will set a precedent determining whether Ontario's Medical Officers of Health have authority to overrule their local board of health or municipality if it fails to introduce effective bylaws to protect the public.

Last October, the Ontario Campaign for Action on Tobacco (OCAT) gave the government a failing grade on its 2<sup>nd</sup> annual tobacco control report card, in addition to recommendations on what needed to be done. The five point plan to reduce tobacco use in the province includes increasing tobacco taxes by at least \$10 per carton, instituting a 100 per cent ban on smoke in all public places and workplaces, dedicating at least \$90 million annually

to a comprehensive tobacco control program for the province, suing tobacco companies to recover health care costs attributable to tobacco-related disease, and a ban on tobacco advertising in retail stores.

The funding of a provincial program could include support for interventions proven to be effective in reducing tobacco use: reducing out-of-pocket costs for effective smoking cessation treatments, patient telephone support (Quit lines), mass media campaigns, and provider education and support for reminder systems. Useful sites to bookmark include OCAT ([www.ocat.org](http://www.ocat.org)) and Guide to Community Preventive Services ([www.thecommunityguide.org](http://www.thecommunityguide.org)).

With an election call imminent, the Liberal Party has announced its promise to strengthen legislation, increase cigarette prices, harness additional taxation revenues to support smoking cessation and alternative agricultural crops, and embark on a anti-smoking campaign

targeted to youth. The announcement caught some media interest in July.

The New Democrats have also made a public commitment to strengthen the Tobacco Control Act and make all public and work places smoke free. In a letter to Heather Crowe, the Ottawa-area waitress who has developed lung cancer from her workplace exposure, Howard Hampton promised to make a comprehensive tobacco control strategy, which includes a 24 hour help line and increased smoking cessation clinics, available to Ontarians. The NDP have also identified the banning of retail displays as a component of the party's anti-smoking strategy.

Clearly, Ontario has fallen behind in its efforts to protect citizens from tobacco-related illness. Solutions have been proposed by researchers, health care professionals, advocates and advisors. What has been lacking is the political will to deal with the issue. Hopefully a provincial election will make a difference. ♦



# MCLELLAN PUBLIC HEALTH ANNOUNCEMENT

*Rosana Pellizzari*

In follow-up to the Calgary think tank on public health organized by MRG member Dr John Frank, a coalition of public health advocates has organized to campaign for a stronger public health system. As one of its first actions, the Coalition issued a media release on August 19<sup>th</sup> to congratulate Canada's Health Minister for her announcement to establish a new Canadian Public Health Care Centre and increase public health capacity.

"The Minister has given early recognition of some of the steps that must be taken to ensure that Canada has an adequately resourced system for public health services that protects and promotes the health of Canadians for today, and for tomorrow's emergencies", said Dr David Butler-Jones, Co-Chair of the Coalition. "Canada also requires leadership from a national public health officer to lead the proposed Centre", Butler-Jones added.

The Canadian Coalition on the Future of Public Health in the 21<sup>st</sup> Century is optimistic that the soon-to-be-released recommendations of the Naylor Advisory Committee will address the need for legislative reform to clearly delineate government responsibilities and public health's role in issues such as drinking water quality, chronic disease prevention, environmental health issues, SARS and emerging communicable diseases.

MRG members have been active in pursuing issues raised by John Frank at the recent members meeting by participating in the coalition. The coalition is calling on government leaders to address 6 key steps to build a public health infrastructure to meet Canada's needs in the 21<sup>st</sup> century:

1. Immediate and continued financial investment in public health. This investment in capacity includes \$1 bil-

lion to the front lines now and a doubling of current spending over the next 5 years.

2. National leadership in public health to provide a focal point, facilitation, coordination and a pan-Canadian approach to Public Health. This includes a National Institution for Public Health, with national, regional and virtual participation under the leadership of a National Public Health Officer.

3. A national information and communications systems for public health which allows timely and adequate surveillance, information sharing, analysis and decision-making across jurisdictions.

4. Strengthened public health human resources to increase capacity, including surge capacity, which includes ongoing continuing education,

5. Legislative reform including a new federal Public Health Act which would, like the Canada Health Act, include criteria and establish mandatory standards which provinces must meet in order to qualify for funding.

6. New financing mechanisms at all levels of government to ensure capacity and accountability for public health delivery.

At the August 18<sup>th</sup> meeting of the CMA in Winnipeg, Health Minister McLellan promised "the Government of Canada will respond, not simply with words, but with concrete, timely action." The MRG has recently written to Minister McLellan to thank her for her stand on the formation of a national Health Council, as recommended by Commissioner Romanow. This week's announcements are further indications that the Minister is on the right track.

# CANADA HEALTH ACT ON TRIAL

*Steven Shrybman*

Earlier this year the Canadian Union of Public Employees, the Communications Energy and Paper Workers Union of Canada, the Canadian Federation of Nurses Unions, the Canadian Health Coalition, and the Council of Canadians decided to take the Federal Minister of Health to court for failing to live up to her obligations under the Canada Health Act. While the delivery of health care services is predominantly a provincial matter under our constitution, federal leadership was needed to establish Canada's medicare system and is now needed to defend it.

The groups are particularly concerned about a proliferation of privatization initiatives that challenge the fundamental principles of universality, accessibility, portability, public administration, and comprehensive upon which the medicare model is based. Ontario, Alberta and British Columbia have been very keen to promote various privatization schemes that would introduce private investment, private funding, or for-profit delivery to whole new areas of the health care system. The groups decided to go to court when their efforts to engage with the Minister around these issues, were ignored.

Their application to the federal court focuses on the responsibilities of the Minister to monitor provincial compliance with, and enforce the requirements of the Canada Health Act. The Minister is also obliged to report annually to Parliament concerning the administration and operation of the Act. The Minister's enforcement and reporting obligations represent essential accountability mechanisms of the Act.

These are supposed to ensure that Parliamentarians and all Canadians are  
*(continued on page 5)*

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# CANADA HEALTH ACT ON TRIAL (continued)

properly informed about whether Canada's health care systems are providing universal access to comprehensive and insured health care services, on uniform terms and conditions to all those covered by the Act.

But as pointed out repeatedly by Auditors General of Canada, successive Ministers of Health have failed to live up to these monitoring, reporting and enforcement obligations. While the audits make the headlines for a day or two, they have had little impact of the Ministers' willingness to take their obligations more seriously.

The need for greater accountability for the performance of Canada's health care system was also a major focus for the Romanow Commission. It recommended the establishment of a new "Health Council" to fill the accountability gap. But the Health Council has now become bogged down in federal and provincial wrangling as several provinces resist efforts that would make them more accountable for their health care systems. Moreover, given the limited mandate and authority of the Council as it was described by the First Minister's Accord, it seems like a poor substitute for the much stronger accountability mechanisms already built into the Canada Health Act.

For instance, under the Canada Health Act the federal government may require provinces to report on the performance of their health insurance systems, and is empowered to withhold funding where the provinces fail to meet the requirements of the Act. But in the face of chronic non-compliance by several provinces, the Minister has simply been unwilling to enforce the Act.

Now, CUPE et al. will seek an order from Federal Court requiring her to do so. In support of their application, the groups have filed evidence in the

form of affidavits from three experts on Canada's health care system. A synopsis of their evidence provides a good summary of what the case is all about.

Pat Armstrong is a professor in the Department of Sociology and in the School of Women's Studies at York University in Toronto. She currently holds a CHSRF/CHIR Chair in Health Services and Nursing Research, and is also the chair of the National Coordinating Group on Health Care Reform and Women. She is also the author or co-author of a large number of articles and books on health policy and politics.

Professor Armstrong confirms the conclusions of the Auditors General and makes the following observation concerning the Minister's efforts to enforcement the Act:

The Minister has also consistently failed to conduct investigations and implement enforcement measures concerning extra billing and user charges in a timely and effective manner. Moreover, with respect to the failure of health care insurance plans to satisfy the criteria of the Act, the Health Minister has chosen to systematically ignore violations of the Act rather than invoke the consultation and other procedures established to resolve such issues of non-compliance. The failure of the Minister of Health to even once invoke these procedures in the face of substantial and persistent evidence of non-compliance suggests that the Minister has adopted a policy of non-enforcement concerning the five criteria that represent the core elements of Canada's health care system.

On the subject of monitoring and enforcement she places much of the blame for the inadequacy of the Minister's reports on a voluntary reporting regime which allows the provinces themselves to determine how much information about their health care

systems will be shared. The result has been a patchwork quilt of information which often defies comparison or meaningful assessment.

As for the consequences of these failures, Professor Armstrong concludes that these include:

- o Parliamentarians and Canadians are deprived of vital information needed for rational policy making, the efficient allocation of health care funding, and effective program design or reform;
- o Widespread misconceptions about the performance of the health care system abound, often creating a sense of crisis where none is justified and undermining public confidence in and support for Canada's medicare system.

At the same time, problems that may undermine the effectiveness of Canada public health care insurance plans remain obscure and are allowed to persist.

Canadians are unnecessarily denied access to comprehensive health care services on uniform terms and conditions because non-compliant practices are often not identified in a timely manner, addressed through the enforcement procedures of the Act, or properly reported to Parliament.

Joan M. Gilmour is a professor of law on the faculty of Osgoode Hall Law School. She has developed and is the Director of Osgoode's new Master's program specializing in Health Law. She is also the past Acting Director of the York University Centre for Health Studies. Professor Gilmour has carried out research and analysis concerning the impacts of privatization on the health care system, and more particularly on access to publicly funded health care services by those covered by the Act.

The purpose of her evidence was twofold. First, to describe how the

*(continued on page 6)*

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# CANADA HEALTH ACT ON TRIAL (continued)

proliferation of initiatives to privatize health care services can undermine the objectives and purpose of the Act. Second, to relate this evidence to the federal Health Minister's obligation to report annually to Parliament concerning the administration and operation of the Act.

Professor Gilmour describes how the twin themes of unaffordability and individual responsibility are being relied upon by these critics of the medicare model to justify a transfer of health care responsibilities from the public to the private sphere, that is, to justify a shifting of costs from the single payer – government – to private individuals and insurers. However, because of the intensity of public support for publicly funded health care, the move towards privatization — by increasing reliance on for-profit delivery and private payment for those services – is being pursued obliquely, either without acknowledging the end result or by focussing attention on the purported benefits of privatization.

Relating these concerns to the Minister's Annual Report to Parliament, Professor Gilmour concludes that it:

- (i) fails to properly document the characteristics of, and changes being made to, provincial health care insurance plans and provincial law and policy, that facilitate the privatization of insured health services; and,
- (ii) fails to consider the consequential impacts of such privatization initiatives on the objectives and purposes of the Canada Health Act including ensuring that all insured persons have access to publicly funded, comprehensive health care services on uniform terms and conditions.

According to the Professor, appropriate reporting to Parliament would not only reveal weaknesses and shortcomings in the publicly funded

system, but its strengths and successes as well. The failure of the Minister's reports to properly report on either creates an information vacuum within which perceptions of the system can be manipulated to serve a particular agenda. In many instances, this agenda will be one that promotes the privatization of Canada's health care system.

Philip Devereaux MD, is currently a clinical scholar and cardiologist in the Department of Medicine at McMaster University and a candidate for a PhD in Clinical Health Sciences (Health Research Methodology) also at McMaster University. He is the recipient of several national awards, and has lead a team of researchers who have published important studies comparing health outcomes in investor-owned private for-profit and private not-for-profit health care delivery systems. Those studies offer compelling evidence that investor-owned for-profit delivery of health care services significantly increases the risk of death to patients, when compared to the not-for-profit delivery of the same health care services.

Dr. Devereaux's evidence introduces the key concept of quality, as an indicia of whether the goals of the Canada Health Act are being met. As his affidavit states:

From a clinical point of view the goals of providing accessible and comprehensive health services to Canadians must be understood and assessed with regard to the quality of services being delivered. Therefore, evaluating the performance of Canada's health care system requires an understanding of both the availability and quality of the services being provided to Canadian residents.

Relating his research work to the Minister's reporting obligations under the Canada Health Act, Dr. Devereaux notes that while Health Canada is making some

effort to track the extent to which insured hospital services are being provided by investor owned for-profit health care facilities, these efforts have failed because most provinces fail to either gather or provide this information. He further notes that with respect to the health outcomes associated with for-profit delivery of hospital services, the Minister's report offers no indication that any effort is being made to gather this information.

Finally Dr. Devereaux concludes that without reliable and accessible information about the extent to which hospital services in Canada are being delivered by investor owned for-profit providers, or the health outcomes associated with such services, the public policy debate about the use of public funding to support investor owned for-profit delivery of hospital services is seriously hampered. It is also impossible to know whether investor owned for-profit delivery of such services is compatible with the goals of ensuring that all Canadians have universal access to comprehensive high quality health care services. ♦

The case should be heard by the Federal Court of Canada, later this year, or early in 2004.

*Steven Shrybman is a partner in the law firm Sack Goldblatt Mitchell.*

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# DO NOT BE DETERRED BY THE RESISTANCE OF THE PROVINCES

*On June 27, 2003, Steering Committee Member Gordon Guyatt sent a letter with the following text to the Minister of Health:*

**W**e are writing to encourage you to insist on the establishment of a Canada Health Council whose membership is dominated by public representatives and academic experts in issues of health care delivery. Roy Romanow correctly identified that to be credible and effective, a Canada Health Council cannot be dominated by individuals representing either the federal or provincial governments. A council of public representatives and experts will be objective, use the available evidence to guide their recommendations, and hold both federal and provincial politicians to account. A council dominated by government representatives will simply be another forum for the airing of federal and provincial disagreements and will therefore be altogether ineffectual.

We would like to recommend individuals whom we think would do a good job representing expert analysis and individuals who would do a good job representing the public interest. We have asked each of the individuals we are recommending whether they would be willing to serve on the Canada Health Council. All have agreed to do so.

As public representatives we recommend the following individuals: Wendy Armstrong, Colleen Fuller, Ethel Meade, and Kathleen O'Grady. As experts on the delivery of health care in Canada, we recommend the following individuals: Joan Bickford, Alba DiCenso, Robert Evans, John Frank, Brian Hutchison, Nuala Kenny, John Lavis, Steven Lewis, Noralou Roos, Greg Stoddart, and Armine Yalnizyan. The attachment to this letter presents the contact information for each of these individuals, and a brief summary of their relevant credentials.

Please do not be deterred by the resistance of the provinces. A strong, independent, and effective Canada Health Council is critical to the future of public health care in our country. ♦

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**Wendy Armstrong** is a policy analyst and consumer advocate with a long-standing interest in health policy issues from a public perspective. Author of three investigative reports on the changing environment for healthcare in Canada and the impact of health system restructuring on Alberta families and communities, she is familiar with issues related to insurance, private and public markets, genetic technologies, medical technologies, information technologies, consumer and patient rights issues in Canada and other countries, and CAM (complementary and alternative medicine). Wendy Armstrong can be reached by phone at (780) 454-9450, by email at [walarmstr@telusplanet.net](mailto:walarmstr@telusplanet.net), or at 11029 - 123 Street, Edmonton, Alberta T5M OE4.

**Colleen Fuller** works in public health policy. She is a member of the board of directors of a community health centre in Vancouver serving some 15,000 east side residents. She is the director of PharmaWatch, a consumer advocacy group on drug safety issues (and also a partner with DES Action), is active in the BC Health Coalition, and is on the national board of the Council of Canadians. In addition, she is the president of the Society for Diabetic Rights, a consumer group. Colleen Fuller may be reached by phone at (604) 255 6601 (h); or (604) 687 1633 (o), by email at [colleen\\_fuller@telus.net](mailto:colleen_fuller@telus.net), or at 2576 Pandora Street, Vancouver, BC V5K 1V8.

**Ethel Meade** has been a community activist focusing on health care issues since her retirement as professor of English Literature at Ryerson University in Toronto. In addition to her involvement in the Older Women's Network, she has served as co-chair of the Ontario Coalition of Senior Citizens' Organizations (an organization concerned with all issues affecting the quality of life of Ontario's seniors), as vice-chair of Care Watch Toronto (focused on home care, particularly supportive care for those suffering from age-related disabilities), and as community co-chair of the Ontario Health Coalition. Ethel Meade may be reached by phone at (416) 363-1289, by email at [gethosp@rogers.com](mailto:gethosp@rogers.com), or at 115 The Esplanade, #1206, Toronto, Ontario M5E 1Y7.

**Kathleen O'Grady** is the Director of Communications for the Canadian Women's Health Network and a Research Associate at the Simone de Beauvoir Institute, Concordia University. She is the editor of several books on women's issues, and numerous reviews and articles, as well as being the editor of *A Friend Indeed*, the health newsletter for women in menopause and midlife. She is a Cambridge Commonwealth Scholar and a former Bank of Montreal Visiting Scholar at the University of Ottawa. Kathleen O'Grady may be reached by phone at (514) 271-7498, by email at [kaogrady54@sympatico.ca](mailto:kaogrady54@sympatico.ca), or at 5244, rue St-Denis, Montreal, Québec H2J 2M2.

**Joan Bickford** has extensive experience at all levels in the health system, beginning with her first position as a public health nurse in rural communities just prior to the advent of Medicare. She was subsequently employed at senior

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## DO NOT BE DETERRED BY THE RESISTANCE OF THE PROVINCES (continued)

provincial government levels in the formulation of health policy, programs, health organization and management, and implementation in all areas. She has been a senior policy adviser in the Deputy Minister's office and more recently has worked in the federal-provincial unit of the Deputy Minister's office. Joan Bickford may be reached by phone at by email at [jbickford@shaw.ca](mailto:jbickford@shaw.ca), by phone at (204)475-6697, or at 900 - 155 Wellington Crescent, Winnipeg, Manitoba R3M 0A3.

**Alba DiCenso** is the CHSRF/CIHR Nursing Chair in Advanced Practice Nursing and a professor in the School of Nursing & Department of Clinical Epidemiology and Biostatistics at McMaster University. Her mandate as a CHSRF/CIHR Nursing Chair is to increase Canada's capacity of nurse researchers who will conduct applied research related to advanced practice nursing (APNs) that serves the needs of managers and policy makers in the health sector. She is the Director of the Ontario Training Centre for Health Services and Policy Research and a co-investigator in a CIHR-funded training centre to increase capacity in interdisciplinary primary health care research and a MOHLTC- funded project to develop interdisciplinary education and service delivery models in long-term care. Alba DiCenso may be reached by phone at (905) 628-4317 (home) or (905) 525-9140, extension 22408, by email at [dicensoa@mcmaster.ca](mailto:dicensoa@mcmaster.ca), or at 78 Davidson Blvd, Dundas, Ontario L9H 7M2.

**Robert Evans** is a professor in the Department of Economics and a faculty member since 1991 of the Centre for Health Services and Policy Research at the University of British Columbia. He is a distinguished academic, an

internationally recognized expert in health economics and a consultant to provincial and federal governments in Canada and abroad. He was a member of the National Forum on Health from 1994 to 1997 and in 1998 was the first recipient of the British Columbia Health Association Legacy Award for his contribution to health policy in the province. Robert Evans is a Fellow of the Royal Society of Canada and is on the editorial board of a number of scholarly publications. Robert Evans may be reached by phone at (604) 822-4692, at email at [bevans@chspr.ubc.ca](mailto:bevans@chspr.ubc.ca), or at the Centre for Health Services and Policy Research, Room 429, 2194 Health Sciences Mall, UBC Campus, Vancouver, British Columbia V6T 1Z1.

**John Frank** is the Scientific Director, CIHR - Institute of Population and Public Health, a professor of Public Health Sciences at the University of Toronto, and a Senior Scientist at the Institute for Work and Health in Toronto, of which he was the founding Director of Research. He is a Fellow with the Canadian Institute for Advanced Research Population Health Program. As a physician-epidemiologist with special expertise in prevention, his main area of interest is the biopsychosocial determinants of health status at the population level. John Frank may be reached by telephone at (416) 946-7878 (c/o Gail Bryant), by email at [john.frank@utoronto.ca](mailto:john.frank@utoronto.ca), or at CIHR Institute of Population and Public Health, Suite 207-L, Banting Building /University of Toronto, 100 College St., Toronto, Ontario M5G 1L5.

**Brian Hutchison** is a professor in the Departments of Family Medicine and Clinical Epidemiology and Biostatistics at McMaster University, Director of the McMaster University Centre for Health Economics and Policy Analysis

(CHEPA), Co-director of the Community Care Research Centre (a research and training partnership of McMaster University researchers and over 30 Hamilton community care agencies), and McMaster Site Director for the Ontario Training Centre in Health Services and Policy Research. A family physician for 30 years, his areas of research include organization, funding and delivery of primary and community care, needs-based health care resource allocation and funding methods, and preventive care. Brian Hutchison may be reached by phone at (905) 525-9140, extension 22123, by email at [hutchb@mcmaster.ca](mailto:hutchb@mcmaster.ca), or at McMaster University, Health Sciences Centre Room 3H1D, 1200 Main Street West, Hamilton, Ontario L8N 3Z5.

**Nuala Kenny** is nationally recognized educator and physician ethicist. She has taught pediatrics in Nova Scotia and Ontario, and has travelled extensively as a distinguished lecturer. In addition, she has served on or chaired a number of committees in the areas of pediatrics and ethics, including chairing the Values Committee of the Prime Minister's National Forum on Health. Dr. Kenny is past President of both the Canadian Pediatric Society and the Canadian Bioethics Society, and was a founding member of the Governing Council of the Canadian Institutes of Health Research (CIHR) and chaired their Working Group on Ethics. In 1999 she was appointed an Officer of the Order of Canada for her contributions to child health and medical education. Nuala Kenny may be reached by phone at (902) 494-3801, by email at [nkenny@tupdean2.med.dal.ca](mailto:nkenny@tupdean2.med.dal.ca), or at the Department of Bioethics, Dalhousie University, 5849 University Avenue, Halifax, Nova Scotia B3H 4H7. Tel: 902-494-3801 Fax: 902-494-3865.

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# DO NOT BE DETERRED BY THE RESISTANCE OF THE PROVINCES (continued)

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**Noralou Roos** is a Professor in the Department of Community Health Sciences at the University of Manitoba, and Director of the Manitoba Centre for Health Policy. Dr. Roos has recently been awarded the Canada Research Chair in Population Health. She was a member of the Prime Minister's National Forum on Health, was a member of the Medical Research Council and its executive, and served on the Executive of the Interim Governing Council of the Canadian Institutes of Health Research. From 1988 - 2002 she was an Associate of the Canadian Institute for Advanced Research. You can contact Dr. Roos at [Noralou\\_Roos@cpe.umanitoba.ca](mailto:Noralou_Roos@cpe.umanitoba.ca)

**Greg Stoddart** is a health economist and health services researcher and one of Canada's leading health policy analysts. He is a Professor in the Centre for Health Economics and Policy Analysis (CHEPA), the Department of Economics, and the Department of Clinical Epidemiology and Biostatistics at McMaster University. He has researched and published extensively on health care financing and organization, in addition to serving on numerous commissions and task forces provincially, nationally, and internationally, and acted as a consultant to the World Health Organization, the World Bank, and several Canadian ministries of health. Greg Stoddart is also well known for his work on the determinants of health, and was a co-founder of the Population Health Program of the Canadian Institute for Advanced Research (CIAR), where he has been a Fellow for the past fifteen years. Greg Stoddart may be reached by phone at (905) 525-9140, ex. 22143, by email at [stoddart@mcmaster.ca](mailto:stoddart@mcmaster.ca), or at the Department of Economics, Health Sciences Centre, Room 2D1, McMaster University, 1200 Main St. West, Hamilton, Ontario L8N 3Z5.

**Armine Yalnizyan** is an economist and activist who has worked with and for community groups since 1985. She has worked with public and private sector partners to develop tools for needs assessment and broker practical solutions, and has written extensively about trends in the labour market and in government social and budgetary policies. She has served on provincial and federal government advisory groups, and has been invited to advise local governments and international organizations on strategic policy development. In 1998 Armine Yalnizyan authored *The Growing Gap*, a ground-breaking report on income inequality in Canada. Since 2001 her work has focused on issues of access to health care. In 2002 she was the first recipient of the Atkinson Foundation Award for Economic Justice; she is using that opportunity to work with the Canadian Centre for Policy Alternatives on the future of Canada's public health care system. Armine Yalnizyan may be reached by phone at (416) 425-1527, by email at [ayal@sympatico.ca](mailto:ayal@sympatico.ca), or at 204 Bayview Heights Drive, Toronto, Ontario M4G 2Z5. ♦

# POLITICIANS BENEFIT PERSONALLY FROM SUPPORTING INVESTOR-OWNED FOR-PROFIT CARE

Last year, I flew to Singapore to participate in a medical conference. The man sitting beside me proved to be a fascinating companion.

Jack (not his real name) is an elite executive who rescues corporations in financial trouble. Jack takes over as CEO of the troubled company, diagnoses the problem, plans the corrective strategy (often employee lay-offs), and implements the solution.

Job done, he moves on to his next assignment.

Jack was curious about my own work as an academic physician. Chatting in the Tokyo airport while changing flights, he had a suggestion for me.

I should consider joining the Board of Directors of some health care companies. Providing a little advice in a few meetings each year, I could make a lot of easy money.

How do you get on these Boards of Directors, I wondered. You have to be friends with the right people, Jack informed me.

Politicians with particular policies get to be friends with the right people. Take Don Mazankowski. The former Conservative deputy-Prime Minister received at least \$204,000 in 2000 for sitting on Boards, and providing advice, for the parent company that owns Great-West Lifeco, one of Canada's largest providers of supplementary health care insurance.

In 2001, Mazankowski produced a report that Alberta has used as a blueprint for changes in health care. Among Mazankowski's recommendations was an expansion of investor-owned, for-profit health care delivery, a development that could ultimately expand business for private health insurance companies.

Members of the House of Commons and the provincial parliament typically wait until leaving politics before starting to pick up fees of \$10 - \$25,000

per board, supplemented by payments to attend meetings.

Not so for the Senate. Many Senators sit on Boards of Directors while still serving their country. Michael Kirby offers an example.

Kirby, the Chair of the Senate Committee on Social Affairs, Science and Technology, produced an influential health care report in 2002 that also included recommendations for expanding investor-owned for-profit health care delivery. Senator Kirby is a Director of Extendicare, a giant for-profit nursing home company, and sits on three of the board's committees.

In this column two weeks ago, I pointed out that research studies have demonstrated that investor-owned, for-profit health care leads to higher hospital and out-patient kidney dialysis death rates than does not-for profit health care delivery. For-profit health care companies have a high incidence of fraud. Fraud represents as much as 10% of total health care costs in the U.S., according to the American Justice Department. Health care Commissioner Roy Romanow found no evidence that for-profit companies deliver care more efficiently, or save money.

I wondered, in the face of the evidence, why Ontario's provincial government is actively expanding investor-owned delivery of health care in hospitals, outpatient MRI facilities, and nursing homes. I suggested that the large donations the Conservative party regularly receives from powerful for-profit companies that ultimately receive government contracts is part of the explanation.

The anticipation of post-politics income offers another explanation. Recent Ontario government decisions in the nursing home sector shows how the system works.

In 1998, the provincial Tory government promised to build 20,000 new nursing home beds before 2006.

The Tories set up rules to favor for-profit companies that have received two thirds of the new beds. At the end of the two decades, the for-profit owners can convert the new facilities, paid for by Ontario taxpayers, to residential apartments.

The province awarded the largest allotment of new nursing home beds to Central Care Corporation, a company controlled by the Toronto-based Reichmann family. The nursing home allocations to Central Care Corporation will generate \$1.36 billion in provincial operating subsidies over the next two decades.

Bill Davis, former Ontario premier, is a founding trustee and the current chairman of Central Care Corporation's parent corporate parent, Retirement Residences Real Estate Income Trust (REIT). A current trustee is former Davis cabinet member, Darcy McKeough. Mr. Davis retains an option to purchase 50,000 trust units for \$10 each. He is paid \$30,000 annually as company chairman. Mr. McKeough has a trustee's option to purchase 45,000 units, and owned 6,000 as of last December.

When now-Premier Ernie Eves' left politics for a year in 2001, he became a REIT trustee. Eves was granted a three-year option to purchase 35,000 trust units for \$10 each, paid a \$15,000 annual retainer, and up to \$1,000 per board meeting. Mr. Eves is now back leading the province, implementing policies to extend investor-owned for-profit health care.

Having a big business-friendly orientation is good for politicians' income when they leave elected office. When the prospect of long-term personal gain tempts politicians into decisions that harm the citizens of the province, like support for investor-owned for-profit health care, it becomes a serious problem. ♦

*First published July 25, 2003 as one of Dr. Guyatt's biweekly columns in the Hamilton Spectator*

# EVIDENCE-BASED MEDICINE IS CHANGING MEDICAL PRACTICE

After a decade of encouraging women who have gone through menopause to take hormone replacement therapy, it's unpleasant telling them that they've been taking a dangerous drug."

The speaker, a family doctor I met at a medical conference, was uncomfortable. She had followed expert advice, and told her patients that they could reduce their risk of heart attacks by using the hormone replacement therapy (HRT). A new study had shown that HRT does not reduce risks of heart attack, and may even increase the risk. Furthermore, the study found that HRT increases breast cancer risk.

"If the experts making the recommendations had understood the principles of evidence-based medicine," says Dr. Brian Haynes, Professor of Medicine at McMaster University, "the family doctor would not have got herself, and her patients, in so much trouble."

Traditionally, doctors have not been taught how to understand original research articles. That means they could not independently decide whether evidence was strong or weak. They were at the mercy of experts, or pharmaceutical representatives. Perhaps even worse, doctors had limited training in helping patients weigh up the benefits, and risks, of alternative therapies.

Many research studies had suggested that HRT could lower cardiovascular risk. But the research had used weak study designs.

So what is a "weak study design"? Consider a study of whether hospitals keep people alive, or kill them. The study shows that people are more likely to die in hospital than in the community. So, hospitals are hazardous, right?

We would laugh at that conclusion. More people die in hospitals not because they are risky places, but because people in hospital are sicker than people in the community.

This problem plagues all "observational" studies. If people taking a treatment are healthier than people who don't, we may falsely attribute life-saving properties to that treatment.

How do researchers solve this problem? They decide who gets treatment by, in effect, flipping a coin. This "random allocation" makes sure that people who get treatment are, at the start of a study, no healthier or sicker than those who don't.

This explains the HRT results. In earlier, observational studies, women taking HRT were at lower risk of cardiovascular disease than women who didn't take HRT. They may have exercised more, had less stress, or been wealthier, all factors associated with better health outcomes.

So, it looked as if HRT reduced heart attacks when, in reality, women taking HRT were destined to have fewer cardiovascular events whether or not they took HRT. The randomized trials revealed the real situation.

There are other examples of doctors going wrong because they didn't respect the principles of evidence-based medicine (EBM). Othopaedic surgeons were sure that they could help patients with painful osteoarthritis of the knee by, in effect, washing the knee out. They inserted a surgical instrument, an arthroscope, into the knee and "washed out" chemicals they believed caused the pain.

In 2002, researchers reported the results of a randomized trial in which patients received the real surgery or "mock" surgery in which surgeons made a cut in the skin, but never used the arthroscope. The result? No difference in pain at any time during two years of follow-up.

How could doctors have gone so wrong? They underestimated "placebo" effects. We often feel better when we receive a treatment we believe is helpful, even if there is no real effect.

McMaster has been a world leader in helping understand such issues. In fact, McMaster may be the single institution that contributed most to EBM.

Dr. Haynes, for instance, has done more than any other researcher in the world to get the evidence to doctors in a clear, usable way.

"EBM still faces big challenges," Dr. Haynes says. "We need to do a better job of helping doctors understand EBM principles, and making sure they have the best evidence at their fingertips. Expert recommendations must reflect the best evidence, and consider patients' values and preferences."

Other health workers can also benefit from understanding and applying evidence-based principles. Nursing, for instance, has its own share of myths. For instance, randomized trials have shown that the widespread practice of shaving patients before surgery increases, rather than decreases, wound infections.

McMaster Professor of Nursing Alba DiCenso has played a key role in establishing evidence-based nursing. Her soon to be released text book will provide the ideal guide for nurses interested in using evidence to guide their practice.

McMaster has also been a key participant in an international effort, the Cochrane Collaboration. The Collaboration's goal is to bring high-quality evidence summaries to doctors and patients. You can join the Cochrane Consumer Network through their website, <http://www.cochraneconsumer.com/>

As they better understand EBM, experts and doctors will create fewer problem stories like HRT and arthroscopic arthritis surgery. And, as a patient, you will receive more accurate information about the benefits and risks of the treatments that medicine has to offer. ♦

*Firat published June 27, 2003 as one of Dr. Guyatt's biweekly columns in the Hamilton Spectator*

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# BAD NEWS FOR ONTARIANS: BOUTIQUE MEDICINE ARRIVES IN TORONTO

*Steering Committee member Irfan Dhalla here shares his July 2 letter to the College of Physicians of Ontario and their July 25 response to him on what he has called boutique medicine. Stay tuned for his report on participating in the review of block fees.*

According to a column in the June 17 *Globe and Mail*, two Toronto doctors have established a practice where they charge patients \$2,500 per year for “a detailed medical workup,” “a customized health care plan,” and “24/7” access.

This type of practice, which has been growing in popularity in the United States since the mid 1990s, and has now crossed the border, is bad news for Ontarians. Today, the Medical Reform Group asked the College of Physicians and Surgeons of Ontario to investigate this issue – commonly known as “boutique medicine.”

“There are about 10 000 family doctors in Ontario. If each of them restricted their practice to 150 patients, as the doctors in the *Globe and Mail* article aim to do, only about 1 out of every 7 Ontarians would have a family doctor,” said MRG spokesperson, Dr. Irfan Dhalla. “Boutique doctors provide extra services for wealthy individuals who can afford to spend thousands of dollars a year to have a physician at their beck and call, but they reduce access for everyone else.”

Even in the United States, boutique medicine has come under criticism. A respected commentator

argued in the *New England Journal of Medicine* that “luxury primary care overall will remain a threat to access.” Some lawmakers are so opposed to the practice that legislation has been introduced into Congress to bar boutique doctors from having access to Medicare and Medicaid payments.

“Provincial insurance plans already pay for necessary medical care. Boutique doctors prey on patient anxiety by charging for services which have no proven medical benefit,” said another MRG spokesperson, Dr. Gary Bloch. ♦  
*Released July 2, 2003*

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## LETTER OF INQUIRY TO THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Re: Possible violation of CPSO policy on block fees

We are writing in response to a *Globe and Mail* column written by Margaret Wenté on June 17, 2003. Wenté describes two family physicians, Dr. Sharla Lichtman and Dr. Rochelle Schwartz, as charging their patients a \$2,500 annual fee for “a detailed medical workup,” “a customized health care plan,” and “24/7” access. Drs. Lichtman and Schwartz are aiming for practices with 150 patients each, rather than the customary 2000 or so.

Drs. Schwartz and Lichtman claim in the article that they are “playing entirely by the rules.” Nevertheless, if the details in Ms. Wenté’s column are correct, it would appear to us that they are violating at least the spirit, and possibly the letter, of the CPSO policy on block fees.

Namely, points 4, 5, and 7 below (reproduced from the CPSO website):

4. The patient must be given the option of paying individual charges for the uninsured services as they are rendered.
5. The decision as to whether or not to elect this form of payment must be the patient’s, and must not be a condition of the patient being accepted by the doctor.
7. Fees for the service of “being available to render a service” cannot be charged in advance and are not to be included in block fees.

We understand that the CPSO’s policy on block fees is to be reviewed by September 2003. We urge the CPSO to consider the issue of “boutique medicine” during this review. These practices have become increasingly

common in the United States and have raised considerable concern (see Brennan TA. *Luxury Primary Care—Market Innovation or Threat to Access*. *New England Journal of Medicine* 346:1165-1168). Although these practices have been endorsed by the American Medical Association, legislation has been introduced into Congress to bar physicians who charge retainers from having access to Medicaid and Medicare funding. We feel strongly that “boutique medicine” is not in the best interest of Ontarians.

We would very much appreciate a response from the CPSO regarding both the specific practices described above as well as the more general issue of boutique medicine. Thank you very much for your attention to this matter. We look forward to hearing from you. ♦

# ONTARIO'S PRIVATE FOR-PROFIT MRI AND CT SCANNERS: SAVIOUR OR SCOURGE?

Bradley MacIntosh and Ted Haines

Requests for Proposals (RFP) for private for-profit MRI and CT services were issued officially by the Ontario Government on November 15, 2002 and closed on January 6, 2003. There were over 700 individuals that asked for an RFP package over all 8 regions (e.g. service providers, media, etc.) and 104 RFP formal applications. The accompanying table shows the list of the 4 companies who won the RFP. Private CT services will not be provided in the City of Brantford because the bid price was too high. Instead, Norfolk General Hospital will receive a CT scanner. The other 7 private centres are said to be open by Dec 7, 2003.

Rules stipulated that no more than 3 regions would be awarded to any one respondent. DC DiagnosticCare Inc., owned by Tory TOP 5 donor Dr. John Mull, was awarded this maximum. In addition,

according to a news release by the parent company, Canadian Medical Laboratories Ltd., their imaging business will receive a tax-cut on payment of facility fees, effective August 1, boasting of additional revenue of approximately \$2.5 million annually.

In the RFP documentation, there is mention of an "independent fairness commissioner" whose job was "to oversee the release and evaluation of the RFPs" and ensure the process was carried out "in a fair and consistent manner".

Attempts by MRG, in addition to other interest groups, to learn the name of this individual and receive a copy of their formal report have failed up until the time of publication. Currently, there is a pending freedom of information document submitted to the Ministry of Health by the Ontario Association of Radiology to ascertain this critical information. It will be used to

independently assess whether the RFP process was in fact fair and consistent.

Pre-licensing inspection of all private MRI/CT clinics will be conducted by the College of Physicians and Surgeons of Ontario (CPSO). The CPSO has acknowledged that "queue jumping", whereby patrons can pay out-of-pocket for medically non-necessary scan, will not be supported. The CPSO also states that all radiological consultations require a requisition from a physician indicating that the procedure is medically necessary.

It remains to be seen how the Tory Government will respond to this constraint, since it was generally assumed by private service providers that such "yuppie scans" would be a means of generating additional profits. ♦

## CPSO REPLIES

Re: Possible Violation of CPSO policy on block fees.

Your letter dated July 2, 2003 has been reviewed. It is unclear from your letter whether you would like this matter investigated as a formal complaint At this time.

The College of Physicians and Surgeons is in the process of reviewing the "block billing" policy. It is possible that you may wish to participate in the review.

If you would like to participate, may I suggest that you contact Ms. Maureen Boon in our Policy Department.

Yours truly,

(original signed by)

G. Patrick McNamara MD CCFP

Associate Registrar

Medical Director, Investigations and Resolutions

Cc Ms. Maureen Boon. ♦

### Winners of the Private For-Profit MRI/CT Scanners

Company	Diagnostic Imaging	City	Financial Connection to Tories
1. Kingston MRI Inc.	MRI	Kingston	None Found
2. KMH Cardiology & Diagnostic Centre	MRI	Vaughan	Contributed \$11,000 to Health Minister Clement's leadership campaign <sup>a</sup>
3. DC DiagnosticCare Inc.	MRI/CT CT CT	Ajax Huntsville Mississauga	Dr. John Mull is president and CEO of parent company Canadian Medical Laboratories Ltd. Total donations to Tories since 1999 at \$105,000 <sup>b</sup>
4. Superior Imaging Inc		Thunder Bay	None Found

<sup>a</sup> The Toronto Star, Feb. 22, 2003: "Four Firms Gain Licenses to Open Diagnostic Clinics"

<sup>b</sup> The Toronto Star, May 24, 2003: "The Fine Art of Giving"

# EXPLAINING MYSTERIOUS GOVERNMENT POLICY

Investor-owned, private, for-profit health care delivery is a bad deal for Ontario citizens. Yet the government is pursuing a policy of handing over health care delivery to profit-making companies. If for-profit delivery threatens public health, and the public pocket book, why is the government persisting?

Is investor-owned health care delivery really such a bad idea? A team of researchers from McMaster University has examined all the research studies comparing investor-owned private for-profit health care to private not-for profit delivery.

These systematic reviews summarize all relevant, high quality research. The results, published in the leading Canadian and American medical journals, showed higher death rates in both the for-profit hospitals and for-profit kidney dialysis clinics.

When investor-owned firms reward shareholders with money that should be going to patient care, they must cut corners. And cutting corners results in higher death rates. The results mean that if we converted all Canadian hospitals to for-profit status, the price would be 2,200 additional deaths each year.

Perhaps if for-profit care saved enough, we could endure the extra deaths in hospitals and use the savings to improve care elsewhere. Health care commissioner Roy Romanow looked hard for evidence of cost savings with for-profit delivery, and found none.

In fact, Canadian experience suggests higher costs to for-profit delivery. For instance, the recently terminated for-profit cancer clinic at Sunnybrook Hospital cost the government \$500 more per patient than the not-for-profit provincial cancer clinics. Furthermore, the figures omit a hidden cost of investor-owned health care: the risk of fraud. In the U.S., where for-profit health care is a much bigger player than in Canada, the Justice Department estimates that fraud costs the health system \$100 billion each year. That doesn't count

the cost of policing. The FBI has 500 agents investigating health care fraud.

With such compelling evidence against investor-owned, for-profit health care, why have the Tories replaced not-for-profit provision of home care services in Ontario with investor-owned delivery? Why have they chosen for-profit firms to run new MRI facilities? Why are they so enthusiastic about public-private partnerships (so-called P3 arrangements) that mandate private sector management of Ontario's new hospitals? Why do they support investor-owned medical laboratories and nursing homes?

Perhaps ideology is the explanation. If your philosophy is that the private sector always does it better, evidence becomes an annoyance to be ignored and dismissed.

Maybe. But a look at whom the Conservatives chose to receive the recently awarded contracts to deliver MRI services in the community suggests another explanation.

Five of the seven facilities will be owned and operated by companies that have made major donations to the Conservative party in the last four years. Canadian Medical Laboratories got three clinics - the maximum allowed under bidding rules. The company donated \$25,000 to the Tories in 1999, more than \$4,000 in 2000, and gave \$10,000 to Premier Ernie Eves' leadership campaign. KMH Cardiology and Diagnostic Centre, which will own and operate two clinics, donated \$11,000 to Health Minister Tony Clement's failed leadership bid.

Looking at the bidders for the contracts to build and manage P3 hospitals shows the same story. Tony Clement received donations last year from partners in all three private consortiums short-listed to build and operate a re-developed Royal Ottawa Hospital. Three consortium companies made donations to Ernie Eves' leadership campaign. Same story in nursing homes. Between 1995 and 1999, long-term care companies donated

\$336,545 to the Conservatives, \$72,918 to the Liberals and \$2,000 to the NDP.

One long-term care company, Retirement Residences REIT, and associated companies have given more than \$17,000 to the Tories since 2002. The companies also gave Eves' leadership campaign \$10,500, Jim Flaherty's campaign \$10,000, and Tony Clement's campaign a whopping \$43,568.

REIT later received contracts to build 2,653 beds, with a potential of over \$1.3 billion in government subsidies. Nursing home giant Extencicare donated \$36,727 to the Tories and got contracts for 1,613 beds. Leisureworld gave Clement's campaign \$18,000 and received 1,895 beds. Same story with laboratories. The Dynacare Health Group, the largest private laboratory company in Ontario, gave Eves \$25,000.

The provincial Conservatives point out that bureaucrats at arm's length from the government make the individual award decisions. Focusing on the impact of political donations on individual funding decisions, however, misses the crucial point.

If new MRI units, like the existing machines, were housed in our hospitals, investor-owned firms would have no opportunity to benefit from expanding diagnostic facilities. If the government used traditional funding mechanisms, no large consortiums could profit from managing publicly-funded hospitals.

What health-care companies expect when they make donations is expanded for-profit delivery. Once in the running for public money, they anticipate their share of success.

So, we have the explanation for provincial government policy. Investor-owned for-profit health care delivery is a bad deal for Ontario citizens, but a great deal for Ontario's Conservative party. ♦

*First appeared July 11, 2003 as one of Dr. Guyatt's twice monthly columns in the Hamilton Spectator*

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# BRAMPTON'S P3 HOSPITAL: WHAT THE CANDIDATES HAVE TO SAY

*Bradley MacIntosh*

The Ontario Progressive Conservative Provincial Government is experimenting with a new financial model for a hospital in Brampton, known as a public-private partnership (P3). The construction deal between the William Osler Health Centre, the 6<sup>th</sup> largest hospital corporation in Ontario with hospitals in Brampton, Georgetown and Etobicoke, and the Healthcare Infrastructure Company of Canada is estimated to cost \$350 - \$380 million.

With the provincial election looming on the horizon, the MRG attempted to contact the three candidates: Joe Spina MPP, Progressive Conservative (PC), Kathryn Pounder, New Democrat Party (NDP) and Linda Jeffrey, Liberals in the Brampton Centre riding on this issue. Despite several reminders Liberal Linda Jeffrey did not respond during the two week period.

All three candidates were asked what future they envisioned for the Brampton P3 hospital. Incumbent Joe Spina explained the Brampton P3 hospital will be built "faster than the more traditional method of accumulating the necessary capital dollars to build hospitals", although, he assured "The Eves Team is fully committed to the principles of the Canada Health Act".

In a secondary question on increased efficiency he suggested that the Brampton P3 hospital would: "attract new medical technologies to work with the [new hospital]", "recruit new medical staff (Resumes are already coming in from around the world!)," and "use the savings from construction costs and put it towards medical services". Unfortunately, Spina did not provide any justification for his anticipated increases in operation efficiency and that we

contact William Osler Health Centre management.

The main virtue seen by Joe Spina justifying the P3 hospital was a savings of time and money at the construction level. After all, the city of Brampton has witnessed a significant population boost.

Given that the NDP has been opposed to public-private partnership in multiple sectors, we asked NDP candidate Kathryn Pounder to provide some insight. Quoting from an example of P3 hospitals in Britain, Pounder stated that "private consortiums make between 15 - 25% profits". She disagreed with the argument that the Government would avoid the capital costs. Paying "inflated lease costs for 25 years", is not cost-effective since "the Government can borrow more cheaply than can the private consortium". Pounder also explained that the promise of speedy construction has been delayed by another year (2006 instead of 2005) due to public-private negotiations in an 8,000 page contract document. Pounder foresees "problems of design, construction, and maintenance problems with these hospitals" due to the incentives of building as "cheaply as possible".

According Jeffrey's website, the Liberals are opposed to the P3 Brampton hospital, since she states "an Ontario Liberal government would work quickly to make these facilities publicly owned". Spina affirmed this statement saying that Jeffrey has promised "to cancel the new [Brampton] hospital". "However, [Liberal leader] McGuinty supports the same P3 financing idea for the new hospital in Ottawa because that's where he lives!"

Pounder is a member of an organization opposed to the P3 Hospital,

the Brampton Health Coalition, and commented that Jeffrey "has shown the [Brampton Health Coalition] no support, she has done nothing to oppose the P3 [Hospital] and now she claims that a Liberal government would work quickly to make these new facilities publicly owned".

Despite the many uncertainties, such as contract-breaking penalties, it seems clear that converting a P3 hospital back to a publicly financed hospital would be quite costly. Under the reign of the PC Ontario Government, an era characterized by cutting and off-loading public services, P3 hospitals seem to be a natural next step. The ominous question remains, however, whether this next step will take Ontario further away from our universally accessible public health care system. ♦

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# MEDICAL NECESSITY AND YUPPIE SCANS

*The Steering Committee is monitoring closely the pressures for expansion of MRI and CT scanning and its implications for access to publicly funded health care in Canada. We reproduce below the text of two recent letters, the first, dated July 16, 2003 from the Registrar of the College of Physicians and Surgeons of Ontario, and the second, dated August 7, 2003, to Health and Long Term Care Minister Tony Clement, seeking clarification on the minister's position on queue jumping.*

**T**hank you for your letter of June 13, 2003. The College of Physicians and Surgeons of Ontario (CPSO) was asked by the Ministry of Health and Long Term Care to undertake the development of Clinical Practice Parameters and Facility Standards to inform the RFP process and to carry out subsequent assessments of services being provided by private MRI and CT clinics in Ontario.

As with the development of all guidelines, the CPSO Independent Health Facilities program formed a task force of experts to complete this task.

The guidelines that resulted from this Task Force are available on line at [www.cpso.on.ca](http://www.cpso.on.ca)

I would like to refer you to Chapter 4: Requesting and Reporting Mechanisms. Several sections in this chapter clearly indicate that it is the intention of the Task Force to ensure that only "medically necessary" tests are carried out.

More specifically, all radiological consultations require a requisition by a physician and must be approved by the quality Adviser of the facility who is also a physician essentially ensuring "medical necessity."

Also on page 21 of the guidelines it states "No screening radiological examination should be performed unless evidence-based or part of an organized population-based screening program."

In the RFP document sent to all bidders there is a section entitled "Queue Jumping." It clearly allows for the CPSO, through the IHF program assessor, to assess non-insured services being provided in MRI and CT facilities.

Therefore, this allows the assessor to check that only appropriately ordered tests are completed and to ensure that there is no broadbased screening taking place.

Based on the above it is clearly the position of the CPSO and the intention of the Task Force who developed these guidelines that queue jumping and broad based screening are not supported. ♦

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**W**e are writing with a concern about the newly established investor-owned, private for-profit community-based MRI and CT facilities.

In early announcements about the facilities, you indicated that they would be allowed to carry out scans intended to screen for disease that had not yet manifested symptoms. Because such screening is not medically necessary, the facilities would be able to charge patients directly for such services. Charges for the services could presumably be set at whatever level the market could bear.

Furthermore, your remarks suggested that, again because they were not medically necessary, persons presenting for such scans needn't be subject to the waiting list rules that would apply to patients needing MRI because of medical necessity.

We have written to the College of Physicians and Surgeons concerning such medically unnecessary screening scans. The College's reply indicates that the College does not support such screening. The College's reply did not, however, indicate what action it could or would take if the clinics violated their guidelines and conducted private-pay screening outside of OHIP.

We would appreciate clarification of your position regarding these scans. Will clinics be allowed to conduct private-pay screening MRI and CT scans? If the answer is no, how does your Ministry intend to monitor to ensure the clinics do not violate the prohibition?

Again, if your answer is that clinics are not allowed to conduct these scans, what penalties do you intend to levy should they nevertheless do so? ♦

# POACHING BY PRIVATE, FOR-PROFIT MRI CLINICS THREATENS HOSPITAL CARE

The Ontario Association of Radiologists are a smart group of doctors. Early in 2002, the provincial government first floated the idea of private for-profit outpatient facilities offering high tech MRI scans. The radiologists predicted that the investor-owned clinics would poach scarce technologists from hospital-based MRI facilities.

In response, Health Minister Tony Clement promised a No Poaching Policy for the new clinics.

Guess what happened. So far, two investor-owned for-profit MRI facilities have opened. Seven hospitals, including Toronto's University Health Network (UHN) and the Kingston General Hospital, have lost technologists to the private clinics.

What about the government's No Poaching Policy?

"You can't control the mobility of the labour market," Premier Ernie Eves has responded.

Right, Ernie, but why then did your government offer its No Poaching Policy?

Not that the government isn't concerned about the function of the hospitals' MRI units. Eves has also said that the Ministry of Health should "ensure that any existing MRI in any public hospital is not prevented from operating through lack of expert personnel."

Unfortunately though, hospital MRI services are affected. Both the Kingston Hospital and the UHN have had to cut back services, and other hospitals may be forced to as well. A senior radiologist from the UHN imaging department has said that "this exodus of techs is causing significant problems in terms of capacity and quality of imaging for us."

How did the clinics persuade the technologists to leave the hospitals? The answer: money. The clinics offer the MRI technologists signing bonuses and higher salaries.

Which brings us to the government's stated reason for turning to investor-owned MRI in the first place. The Tories claim that the clinic's operating costs are cheaper than

the hospitals'. Unfortunately, the government won't say how much it's giving each clinic, and the contracts are privileged information, not open to public scrutiny.

The government's refusal to provide the needed information prevents us from assessing its claim that the for-profit clinics will cost less than not-for-profit hospital facilities. But, just as a matter of logic, how could the for-profit clinics costs be less if they are paying their technologists more?

I asked Dr. Harald Stolberg, a Hamilton radiologist with more than 40 years involvement in the specialty at local, national, and international levels, that question.

"Hospitals deal with sicker patients," Stolberg explained, "conducting the scans, and interpreting them, will be more time-consuming and expensive than in the community."

But if that's true, the government won't really be saving money at all?

"Right," said Stolberg. The practice of treating less sick, and therefore less expensive patients, is sometimes called "cream-skimming". American private for-profit health care providers often use cream-skimming to maximize their profits.

Stolberg offered other explanations. "The facilities may cut corners, and reduce standards of service where it is least visible."

That made me think of two reviews from McMaster that summarized all the high quality studies comparing death rates in private for-profit, versus private not-for-profit, hospitals and dialysis centers. Both reviews found higher death rates in the private for-profit facilities, likely a result of the sort of corner-cutting that Stolberg fears.

Finally, Stolberg thinks the facilities are planning to conduct so-

called "yuppie scans". They will screen healthy individuals with MRI, looking for illnesses like cancer and heart disease, charging what the market will bear.

Tony Clement has vowed that he will not allow the for-profit clinics to charge patients who would like to bypass MRI waiting times by paying to jump the queue. Let's call this Tony's No Queue-jumping Policy. It is unclear whether Clement has any better enforcement mechanism in mind than he did for the No Poaching Policy.

Whatever the enforcement plan, the rule against direct patient charges only applies to medically necessary services. Yuppie scans are unproven. In fact, they may show abnormalities that require further dangerous and expensive testing, but turn out to be harmless. They may therefore do more harm than good. Because their benefit is unproven, yuppie scans are not considered medically necessary, and so not subject to the prohibition against direct patient charges.

The College of Physicians and Surgeons, the body responsible for protecting the public against possible physician misbehavior, has said that as far as it is concerned, the clinics should not be doing yuppie scans. The College is making that recommendation because yuppie scans are potentially dangerous. They would also, however, rob MRI slots from patients who really need the test. Clement has been repeatedly asked whether his Ministry will allow the clinics to charge patients for yuppie scans. So far, he has not provided a direct answer.

By poaching technologists, the investor-owned MRI facilities are threatening the care of hospital patients. Dr. Stolberg's observations make it clear that technologist poaching is only one reason why investor-owned for-profit MRI scanning is a bad idea. ♦

*First published Augst 22, 2003 as one of Dr. Guyatt's biweekly columns for the Hamilton Spectator*

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# NEW RESEARCH AND CAMPAIGN NEWS FROM PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

## ADMINISTRATIVE COSTS IN MARKET-DRIVEN U.S. HEALTH CARE SYSTEM FAR HIGHER THAN IN CANADA'S SINGLE-PAYER SYSTEM: *New Research Shows With National Health Insurance, United States Could Cover the Uninsured*

WASHINGTON, D.C. — Bureaucracy in the health care system accounts for about a third of total U.S. health care spending — a sum so great that if the United States were to have a national health insurance program, the administrative savings alone would be enough to provide health care coverage for all the uninsured in this country, according to two new studies.

The studies illustrate the failure of the private, fragmented and business-oriented U.S. health care system to control administrative costs, as compared to Canada's single-payer system. One of the studies, in seeking to answer whether the ascendancy of computerization, managed care and more businesslike approaches to health care have decreased administrative costs, answers the question with a resounding "no."

The second study provides a state-by-state breakdown of savings each state could achieve if the United States adopted a national health insurance program.

"Hundreds of billions are squandered each year on health care bureaucracy, more than enough to cover all of the uninsured, pay for full drug coverage for seniors, and upgrade coverage for the tens of millions who are under-insured," said Dr. Steffie Woolhandler, co-founder of Physicians for a National Health Program and lead author of the studies. "Americans spend almost twice as much per capita on health care as Canadians, who have universal coverage and live two years longer. The administrative savings of national health insurance make universal coverage affordable."

*New England Journal of Medicine Study Shows U.S. Health Care Paperwork Cost \$294.3 Billion in 1999, Far More Than in Canada.*

The first study, which is to be published Thursday in *The New England Journal of Medicine*, finds that health care bureaucracy cost U.S. residents \$294.3 billion in 1999. The \$1,059 per capita spent on health care administration was more than three times the \$307 per capita in paperwork costs under Canada's national health insurance system. Cutting U.S. health bureaucracy costs to the Canadian level would have saved \$209 billion in 1999, researchers found. [The study was conducted with grant support from the Robert Wood Johnson Foundation. The Foundation does not endorse the analyses or findings of this report or those of any other independent research projects for which it provides financial support.]

The study, the most comprehensive analysis to date of health administration spending, was conducted by researchers at Harvard Medical School and the Canadian Institute for Health Information, Canada's quasi-official health statistics agency. The authors analyzed the administrative costs of health insurers, employers' health benefit programs, hospitals, nursing homes, home care agencies, physicians and other practitioners in the United States and Canada. They used data from regulatory agencies and surveys of doctors, and analyzed Census data and detailed cost reports filed by tens of thousands of health institutions in both nations.

The authors found that bureaucracy accounted for at least 31

percent of total U.S. health spending in 1999 compared to 16.7 percent in Canada. They also found that administration has grown far faster in the United States than in Canada. Between 1969 and 1999, administrative and clerical personnel in the United States grew from 18.2 percent to 27.3 percent of the health work force. In Canada, those personnel grew from 16 percent in 1971 to 19.1 percent in 1996.

*Harvard/Public Citizen Report Finds National Health Insurance Would Save \$286 Billion on Administration in 2003 - Enough to Cover All Uninsured and Seniors' Drug Costs*

The researchers also released a second report co-authored with Dr. Sidney Wolfe, director of Public Citizen's Health Research Group. This report, based on data adjusted to reflect estimates of 2003 spending, found that health bureaucracy now consumes at least \$399.4 billion annually and that national health insurance could save about \$286 billion in administrative costs. This is equivalent to \$6,940 for each of the 41.2 million people uninsured in 2001 (the most recent figure available for the uninsured). In addition to providing health coverage for the uninsured, these savings could provide drug coverage for the nation's seniors.

The researchers found wide variation among states in the potential administrative savings available per uninsured resident. Texas, with 4.96 million uninsured (nearly one in four Texans), could make available \$3,925 per

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## NEW RESEARCH AND CAMPAIGN NEWS FROM PHYSICIANS FOR A NATIONAL HEALTH PROGRAM (continued)

uninsured resident if a national health plan were implemented. Massachusetts, which has very high per capita health administrative spending and a relatively low rate of uninsured, could make available \$16,453 per uninsured person.

The high U.S. administrative costs can be attributed to three factors. First, private insurers have high overhead in both nations but play a much bigger role in the United States than in Canada. Second, doctors and hospitals in the United States must deal with hundreds of different insurance plans (at least 755 in Seattle alone), each with different coverage and payment rules and referral networks that must be tracked. In Canada, doctors bill a single insurance plan, using a single simple form, and hospitals receive a lump sum budget.

“Only national health insurance can squeeze the bureaucratic waste out of health care and use the money to give patients the care they need,” said Dr. David Himmelstein, co-founder of Physicians for a National Health Program and lead author of the studies.

“Republicans are pushing to move seniors into HMOs, whose overhead is three times higher than Medicare’s. National health insurance could cover everyone without any increase in costs.”

Added Wolfe, “These data should awaken governors and legislators to a fiscally sound and humane way to deal with ballooning budget deficits. Instead of cutting Medicaid and other vital services, officials could expand services by freeing up the \$286 billion a year

wasted on administrative expenses. In the current economic climate, with unemployment rising, we can ill afford massive waste in health care.

Radical surgery to cure our failing health insurance system is sorely needed.” ♦

*Drs. Woolhandler and Himmelstein are co-founders of Physicians for a National Health Program, a 10,000-member organization that advocates for Canadian-style national health insurance in the United States. Public Citizen is a non-profit, member-supported, consumer advocacy organization.*

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## DOCTORS CALL FOR NATIONAL HEALTH INSURANCE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION PUBLISHES PHYSICIANS’ PROPOSAL FOR NATIONAL HEALTH INSURANCE SIGNED BY 7,782 PHYSICIANS

WASHINGTON, D.C., AUGUST 11, 2003 — In an unprecedented show of physician support for National Health Insurance (NHI), 7,782 U.S. physicians propose single payer NHI in an article in the August 13 issue of the *Journal of the American Medical Association* (JAMA).

The “Physicians’ Proposal for National Health Insurance” was drafted by a blue ribbon panel of leading physicians. The signers include 2 former U.S. Surgeons General, the former Editor-in-Chief of the *New England Journal of medicine*, hundreds of medical school professors and deans, and thousands of practicing doctors throughout the nation. The Proposal will

be presented in D.C. at The National Press Club on August 12 at 10am in the Murrow room.

“This is an historic moment. Today, thousands of physicians are taking a stand on the side of patients and repudiating the powerful insurance and drug lobbies that block wholesome reform,” said Dr. Quentin Young, a leading Chicago physician who chaired the Department of Medicine at Chicago’s Cook County Hospital and convened the group of prominent physicians that drafted the proposal.

The doctors’ article also critiques the health reform plans that have been offered by President Bush and the major Democratic presidential contenders. “Proposals that would retain the role of

private insurers - such as calls for tax-credits, Medicaid/CHIP expansions, and pushing more seniors into private HMO’s - are prescriptions for failure. By perpetuating administrative waste, such proposals make universal coverage unaffordable,” said Dr. Young.

The physicians call for national health insurance that would cover every American for all necessary medical care - in essence an expanded and improved version of traditional Medicare.

\* Patients could choose to go to any doctor and hospital. Most hospitals and clinics would remain privately owned and operated, receiving a budget from the NHI to cover all operating costs. Physicians could

*(continued on page 20)*

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## NEW RESEARCH AND CAMPAIGN NEWS FROM PHYSICIANS FOR A NATIONAL HEALTH PROGRAM (continued)

continue to practice on a fee-for-service basis, or receive salaries from group practices, hospitals or clinics.

\* The program would be paid for by combining current sources of government health spending into a single fund with modest new taxes that would be fully offset by reductions in premiums and out-of-pocket spending.

\* The proposed single payer NHI would save at least \$200 billion annually by eliminating the high overhead and profits of the private, investor-owned insurance industry and reducing spending for marketing and other satellite services.

\* Administrative savings would fully offset the costs of covering the uninsured as well as giving full prescription drug coverage to all Americans.

“In the current economic climate, we can no longer afford to waste the

vast resources we do on the administrative costs, executive salaries, and profiteering of the private insurance system”, states Dr. Marcia Angell, Senior Lecturer in the Department of Social Medicine at Harvard Medical School, and former Editor-in-Chief of the *New England Journal of Medicine*. “We get too little for our money. It’s time to put those resources into real health care—for everyone.”

The physicians’ call for NHI comes as rising health costs and premiums, and the increasing number of uninsured have stimulated a new round of health reform initiatives. Yet most politicians have steered clear of NHI, offering proposals for incremental reforms of the current system.

“How bad does it have to get before politicians are willing to prescribe the major surgery our health system needs? Premiums are skyrocketing and we already spend twice as much per

capita on health care as any other nation. 41 million people are uninsured, and millions more are under-insured and can’t afford vital medicines. How bad does it have to get before our politicians admit we need national health insurance?” asked Dr. Steffie Woolhandler, lead author of the proposal and Associate Professor of Medicine at Harvard.

The full list of signers is available on the internet, but will be password protected until the JAMA’s embargo is lifted. To obtain a password, members of the press may call (312) 782-6006. Physicians for a National Health Program was founded in 1987 and includes physicians in every state and medical specialty. For local contacts or other information, contact PNHP’s headquarters in Chicago at (312) 782-6006 or visit: [www.pnhp.org](http://www.pnhp.org). ♦

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## EQUITY VS. EQUALITY: MRG PRINCIPLES GO UNDER THE KNIFE

*Gary Bloch*

Over the past few months, the Medical Reform Group steering committee has been grappling with a number of issues that strike at the heart of the MRG’s self-definition. Readers may have noticed the lively debate around the MRG’s involvement in international issues that emerged in the last few issues of the Newsletter. It is this type of debate that reaffirms the MRG as an organization dedicated to analysis and progressive change.

Another vigorous discussion that has been evolving over the past 6 months

centres on the definition of “equity” in the MRG’s statement of principles. Participating in this discussion highlighted the excitement – and some of the challenges – of belonging to an organization that questions and pushes ideological boundaries.

Those ideological boundaries were first laid out with the formation of the MRG twenty four years ago. At that time, a group of physicians who considered themselves likeminded in their progressive values developed an alliance for strength and support, and created a set of “principles” that would

define the ideological direction of the budding Group. Those principles, centered on a dedication to accessible, affordable health care for all, have stood as the foundation for the MRG for over two decades.

As the health care system changes, and as society and progressive thought change, so must our principles. A few months ago, spurred on by the urgings of a new MRG member, members of the steering committee began to re-examine the “principles” document. We reaffirmed the core belief in universal,

*(continued on page 21)*

# EQUITY VS. EQUALITY: MRG PRINCIPLES (continued)

accessible health care. Debate arose, however, around the definition of equity in the context of health resource distribution.

Prior to this discussion, the principles document stated:

**Equity** – Everyone should have equal opportunities to make use of available health care resources, and equal opportunity to live in an environment conducive to good health.

Critics of this statement dissected the notion of “equal opportunity”. Members charged that it is insufficient to simply level the playing field for Canadians in obtaining access to health care, i.e. to allow each person as much opportunity as the next to access resources.

In reality, Canadians have fundamentally different starting points in their health access needs, and therefore an equitable system requires that some people have greater opportunity to access care than others. In its most obvious form, this opportunity would be determined based on pure urgency of a patient’s medical condition. For example, a patient with a brain tumour likely should have easier access to an MRI machine than one with non-debilitating knee pain.

The MRG, however, embraces a far broader definition of health than one based on an individual’s physical wellbeing, one that includes physical, psychological and social status. Using this broader definition, the discussion around equity becomes more socially based, and takes on greater transformative potential in our society.

Under this conception of equity, health resource distribution requires proactive efforts to correct social inequality. Therefore, to create equity, groups with historically disadvantaged

access to care should be specifically targeted with health resources. To this end, for instance, money may need to be diverted from specialized quaternary care services (such as heart transplant surgery) to primary care or public health programs focused on disadvantaged groups (such as harm reduction programs for inner city drug users, or diabetes prevention programs on First Nations reserves).

In other words, equity should be judged not only by access to care, but by equity of health outcomes as well. And these outcomes need to be determined on a broad social as well as an individual level.

After much debate, the members involved in this discussion agreed on a new phrasing for the MRG’s equity statement:

**Equity:** Health resource allocation initiatives should be evaluated by their impact on the equity of health outcomes. These outcomes should be measured based on 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

This statement better reflects the socially-determined vision of equity that we believe the MRG holds at its core.

The debate is in no way over. It is presented as a starting point for discussion amongst the wider MRG membership. It is this type of debate that keeps an organization such as the MRG vibrant and truly progressive. We welcome the input of all members on this and every other element of our “principles.” One of the greatest mistakes a progressive organization can make is to fail to progress itself. ♦

# MRG STEERING COMMITTEE

The Steering Committee is a small but dedicated group which includes a range of disciplines, mainly living in the so-called Golden Horseshoe of southern Ontario. They are keen to engage other members, and can be reached through the office. To give a sense of their interests, here are some short biographies.

**Ahmed Bayoumi** is a general internist and health services researcher in Toronto. His clinical and research interests focus on the health of people living with HIV and other disadvantaged populations. He is committed to the concepts of social and economic justice, which he views as incompatible with capitalism.

**Gary Bloch** is currently a final year resident in family medicine at St. Michael’s Hospital in Toronto. He has, since his inception into the medical world a half decade or so ago, set his sights firmly on a career in inner city health. He’s spent far too much of his short life obsessed with inequality, and he may be one of the first people to consider colonial history an appropriate prerequisite area of study to medicine.

Consistently, however, he has found that the biggest impact he has in his work comes when he approaches health through a lens of historical disadvantage. While he knows that this disadvantage is even more pronounced outside of a first world city than in it, he is way too addicted to the smog-enhanced beauty of an urban sunset, and to instant access to top quality (fair trade of course) coffee, to leave ... so the inner city it is!

(continued on page 22)

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# STEERING COMMITTEE (continued)

**PJ Devereaux** is a cardiologist and health care researcher who is currently advancing his education in clinical epidemiology at McMaster. Among the issues about which he feels strongly is a physician's interaction with the pharmaceutical industry. Dr. Devereaux does not accept gifts or free food from the pharmaceutical industry, and his principled stand was recently highlighted in a major article in the *Globe and Mail*.

**Irfan Dhalla**, a recent medical school graduate, is an internal medicine resident at the University of Toronto. As a medical student, he helped lead a national medical student survey that showed increased tuition fees are having negative effects on the medical student population. He is currently interested in developing and using evidence-based health policy to defend the rights of the more vulnerable populations in our society.

**Mimi Divinsky** is a family physician in downtown Toronto, a Fellow of the College of the Family Physicians of Canada and a lecturer in the Dept. of Family and Community Medicine at the U of Toronto. She was, until a recent illness, medical co-director of the Sexual Assault Care Centre at Women's College Hospital. Dr. Divinsky has been active in the Medical Reform Group since the group's inception, and has played an important role on the Steering Committee since 1985.

**Gordon Guyatt** is a Professor in the Departments of Clinical Epidemiology and Biostatistics and Medicine at McMaster University. He has made important contributions to clinical and health care research, recognized by over 350 publications in peer-reviewed journals. His educational work includes seven years as Director of the Internal

Medicine Residency Program. His work in dissemination of evidence-based decision-making was recognized by a McMaster University President's Award for Excellent in Resource Design in 1996. Dr. Guyatt was instrumental in founding the Medical Reform Group in 1979 and has spent most of the subsequent two decades as a spokesperson for the group. He has contributed to the development of MRG policy, and in recent years has taken a major role in packaging and dissemination of MRG approaches to health issues.

**Ted Haines** helps people and workplaces solve occupational health problems. While recognizing, imperfectly, the massive barriers posed particularly by powerful political and corporate forces, he doesn't see why Canadians shouldn't have a health care system that protects and cares for them, irrespective of means. That would be part of the society we want. He's a co-chair of the Hamilton Health Coalition and on the administrative committee of the Ontario Health Coalition. "Entre la jeunesse et la sagesse".

**Bradley MacIntosh** holds a Master degree in Medical Biophysics and is currently working towards his doctorate in Imaging Research at Sunnybrook and Women's CHSC. His research utilizes novel functional techniques with Magnetic Resonance Imaging with the application to brain diseases such as stroke. He views health as a basic human right, and recognizes that struggle for social justice fought and won in Canada are linked to global well-being.

**Adam Newman** is a family physician in Kingston. He works at a Community Health Centre where he helped to develop Kingston's first integrated primary care nurse practitioner program.

After spending two years as a staff physician in Sioux Lookout, working with First Nations people in remote and underserved communities, he has continued working with marginalized and poorly served populations in Kingston. These include: the unemployed; those on social assistance; the disabled; intravenous drug users; and street youth. He is also active in the areas of Family Planning and contraception. In all of these areas, he maintains an interest in advocating for patients whose health suffers due to social and economic inequality, and who are threatened by moves to limit universal access to high quality publicly supported health care.

**Rosana Pellizzari** is a Family Physician at a downtown Toronto community health centre serving a culturally diverse, low-income neighbourhood. As an Assistant Professor in the Department of Family and Community Medicine, she is actively involved in the training of medical students, Family Medicine Residents and midwives. She writes regularly for the *Toronto Star* and has hosted a national daily TV health program in the recent past. She has served as Chair of the local Board of Public Health and President of the Association of Ontario Health Centres.

Dr. Pellizzari worked as a community organizer and adult educator prior to entering medicine. She has experience working on health issues in aboriginal, Latin American and Asian communities. She has completed additional post graduate training in epidemiology and community health. She is involved in multicultural and refugee health issues, women, violence and poverty issues.

**Yves Talbot** is Associate Professor in the Department of Family and

*(continued on page 23)*

# STEERING COMMITTEE (continued)

Community Medicine and Health Administration at the University of Toronto and Director of the International Programs in the department of Family and Community Medicine. He has been involved in South America since August

1995 in programs of Capacity Building in Primary Care. The programs are aimed at training teams of professionals working in different cities of Brazil, Chile and Argentina. Dr Talbot has served on the Ontario (PECCCAR) Committee for Primary Health

Care Reform and has a particular interest in the role of primary care and questions of Equity. ♦

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# READERSHIP SURVEY

*Janet Maher*

The Steering Committee commissioned a survey on the newsletter in our spring issue, and here is a brief summary of the feedback received from about 15 per cent of the membership. The Steering Committee will be reviewing the findings in the next month, with a report to the fall meeting, and so we may be looking at some revisions to our format later this year.

With regard to the preference for electronic or hard copy of the newsletter, 58 per cent were content to receive by e-mail, whereas 29 per cent prefer to continue receiving a hard copy. Thirteen per cent would make use of both electronic and hard copy. Of those prepared to receive an electronic version almost half would use PDF; just over 20 per cent would prefer a document in MS Word; the remainder were not sure.

Regardless of their own preferences, nearly all members who responded thought we should provide unlimited free access to the newsletter on the web; and the great majority thought there should be no differential fee for paper copies of the newsletter.

In response to our questions on length and frequency, 54 per cent thought we could consider a shorter newsletter with a more frequent publication schedule. Fourteen percent thought we should publish more but less often, and a third preferred the current quarterly schedule. In terms of length, 15 per cent thought our current articles were too long, 5 per cent thought they were too short, and 80 per cent liked the current mix.

Sixty per cent of respondents read several articles or all of each newsletter, and the remainder glanced through or read a few articles.

Several respondents expressed an interest in contributing to the newsletter, but with one exception declined to identify themselves. In general the Steering Committee got high marks for being topical and informative.

Among the issues recommended for newsletter coverage in future:

- More on international comparisons, global health issues (5 respondents)
- More on mental health reform
- What about unionizing family physicians?
- What about internet care of patients?
- Focus on MD position on issues
- More on primary care reform, capitation and alternative payment schemes. ♦

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