

# MEDICAL REFORM

Newsletter of the Medical Reform Group

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## REVISITING THE 2004 ONTARIO LIBERAL BUDGET

Brad MacIntosh

According to national polls, health care continues to be the number 1 issue for Canadians. It is not surprising then, that in riding-rich Ontario (106 of the 308 Federal seats), McGuinty's controversial Ontario Budget, delivered May 18, 2004, may hurt Paul Martin's chances of becoming an elected Prime Minister of Canada. The Budget's health care section is worthy of both praise and criticism.

The two main health items in the budget that caused an Ontario groan were: introduction of a health premium tax, and delisting of OHIP services, which include physiotherapy, chiropractic services, and routine eye exams (note exceptions exist, for example, seniors in Long Term Care Centres) as not "medically necessary."

According to statistics from Canadian Institute of Health Information, between 1990 and 2001, healthcare accounted for approximately 38 per cent of the Ontario government's total spending. Introducing a healthcare premium seems somewhat redundant, since this is where most of Ontario's dollars go in the first place. In line with the two other provinces that currently have health premiums, British Columbia and Alberta, a health premium is an effective means of ensuring that healthcare remains a hot political item. Ontarians may react with a renewed sense of individual entitlement.

In addition, a key feature of the Ontario premium is problematic. Individuals that make less than \$20,000 will pay no health premium, individuals with \$20,000 taxable income will pay \$300 a year, and taxable incomes over \$200,000 will pay \$900. The key concept about progressive taxation is that it has to be "progressive" to be called "progressive".

A quick calculation reveals that the health premium tax is in fact regressive, with lower income Ontarians taking on a larger tax as a function of their income. For example, by dividing the health premiums by the prescribed taxable income brackets, the lowest income earners pay 1.5 per cent of their income for their health premium, while the highest income bracket pays 0.45 per cent of their income. You have to

wonder how the Ministry of Health came up with these numbers.

In the second case, delisting of OHIP services continues to be used as a "fix" for provincial governments attempting to balance their budgets. In the case of Ontario, this practice dates back a decade or so when cosmetic procedures such as tattoo removal were de-listed. The Progressive Conservative governments followed suit, eliminating more procedures and limiting the extent to which others would be paid from the public purse. This time around Liberals decided to pull items a number of lower cost but frequently used procedures. For instance, bi-annual routine eye exams that cost \$58.25 per consultation will no longer be available (except for children and seniors).

Health care advocates are increasingly concerned about how a service is delisted, since there is a clear lack of transparency. What consultation takes place with health care interest groups prior to decision making? To our knowledge, although the NDP provided for citizen input into the delisting they begin in 1991, but no systematic review has since been undertaken to assess the "medical necessity" or otherwise of items delisted since then. For instance, physiotherapy costs \$125 for the first consultation, then \$23 for subsequent visits, which in the grand scheme of things is not a lot of money, but is an integral component to recovery

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<http://www.hwcn.org/link/mrg>

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## Medical Reform

*Medical Reform* is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at \$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 <medicalreform@sympatico.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:** Brad MacIntosh, 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.

## REVISITING THE 2004 ONTARIO LIBERAL BUDGET (continued)

of injuries or maintaining an independent lifestyle.

Importantly, the budget also included goals of 36,000 cardiac procedures per year by 2007, 2,300 more joint replacements by 2007, 9 new MRI and CT sites by next year, 9,000 more cataract surgeries per year and an immediate injection of \$600M to support primary care reform. The budget does make a commitment to illness prevention, for example \$156M was added for three new

vaccines for children's immunization. However at press date, there still was no word on canceling the private MRI and CT systems in Ontario.

The Liberals have broken one of their election promises: effectively, they raised taxes—it seems to us the premium as designed would be a tax 'by any other name'—and further politicized health care at the same time. ♦

*Brad MacIntosh is co-chair of the Toronto MRG Student Chapter.*

## MAY 18TH ONTARIO BUDGET HEALTH CARE HIGHLIGHTS

### *Service improvements*

- additional 36,000 cardiac procedures per year by 2007
- additional 2,300 joint replacements per year by 2007
- 9 new MRI and CT sites next year
- 9,000 additional cataract surgeries per year
- \$600m to support primary care reform from 2004

### *Health Human Resource Improvements*

- 150 Family Health Teams over 4 years
- \$14m to 54 existing CHCs, more new ones
- insure care this year for 167,000 Ontarians who cannot find a doctor
- home care for additional 95,700 Ontarians by 2007
- end of life care at home for 6,000 by 2007
- additional support for Long Term Care: \$406m in 2004 to \$546m in 2007

### *Funding for Hospitals and Public Health*

- multi-year hospital funding with increases around 3.4 per cent annually
- healthy living—vaccinations and smoke-free workplaces
- public health up \$273m to \$469m by 2007
- increase provincial share of public health funding to 75 per cent by 2007
- double spaces for international medical graduates and nurse practitioners
- 8,000 new full-time nursing positions over 4 years
- 12,000 bed lifts to prevent injuries to nurses

### *The Costs*

- delist less critical services as of September:
  - ♦ routine optometry except for seniors and under 20
  - ♦ chiropractic and physiotherapy except in Long Term Care
- health premiums on a sliding scale from \$300 to \$900 annually for taxable incomes over \$20,000 from July 1, 2004

For commentary on the 2004 Ontario Budget and other federal and provincial government initiatives, please see <http://www.policyalternatives.ca>.

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# SIMPLE, APPEALING, AND WRONG

**N**eed surgery, medical tests? Go to the end of the line. Find this message familiar? You should - you've been hearing it for quite a while. *The Globe and Mail* published that headline in 1989.

Two weeks ago in this column, I argued that much of medical care is discretionary - in other words, benefit is uncertain or marginal - and that rationing of care will always be necessary. Waiting lists are an inevitable by-product of a rationing approach that limits resources such as fancy equipment, operating room slots, and emergency room beds.

That approach to rationing - the best available - asks doctors to attend first to those who need care the most. I also pointed out that there are few hard facts about how many Canadians suffer important harm waiting for care. Nevertheless, surveys tell us many patients are distressed by long waits. Occasional stories of patients suffering serious consequences while waiting also suggest we have a real problem.

So what are the solutions?

The influential Kirby Senate report recommended governments set maximum waiting times for medical procedures. If the deadline passes, a patient could go to a private clinic in Canada or abroad, with the government picking up the tab.

This solution is simple, appealing - and wrong.

First, parallel private clinics will ensure waiting times stay long. Doctors running those clinics need to ensure patients are sufficiently frustrated by waits that someone - patients, insurers, or the governments - will pay for private care. Second, a number of European countries have tried waiting time guarantees. The cure has proved worse than the disease.

Guarantees have not reduced the number of patients on the waiting list,

or average wait times. One reason is that as soon as the list shrinks, less sick or needy patients - the least likely to benefit - sign on.

More important, the guarantees focus excessive attention on those nearing what some have described as the 'line of failure, shame and blame'. Doctors start to see patients approaching the deadline before they see new patients with more pressing needs.

Thus, wait time guarantees result in a set of perverse incentives. For patients, get on the list early, even if your problem is trivial. After all, it might get worse, and once on the list, the clock starts ticking.

For specialists, have lots of quick short first appointments to ensure patients get off the wait list. Unfortunately, the process of actually sorting the problem out may lengthen interminably.

All this runs counter to principles of sensible care. Norway, Sweden, and Denmark have all tried and abandoned guarantees. Where they persist, they create an unhealthy tension between treating according to need, and treating according to time on the list.

There are better solutions. First, we need reliable monitoring systems to determine the size of the problem. Such systems must not only count people waiting, and how long they wait, but also document their illness severity. We need this information to ensure that the effort to solve waiting time problem is in line with its magnitude.

Second, we must develop and apply uniform standards for acceptable waits for different sorts of problems. Evidence to date suggests that individual doctors apply widely varying criteria.

Third, we need regional systems to co-ordinate access to procedures with long wait times. This kind of co-ordination has allowed cardiac care in Ontario and breast cancer care in Britain to ensure the sickest patients get treated first,

and to minimize administrative inefficiencies.

Fourth, at times we will require additional resources to, for instance, expand operating room slots, or build more MRIs.

These four strategies apply to waits for elective surgery and high-tech diagnostic tests. What about emergency rooms, an area of ongoing controversy in Winnipeg?

Primary care reform with 24-hour access to family doctors' care may cut down on the walking wounded - those less sick patients with whom emergency room doctors can quickly deal. Because such patients require little time, reducing their volume will likely have limited impact on long waits.

Patients already seen and admitted to hospital, but stuck in emergency waiting for unavailable hospital beds, constitute a much larger problem in big-city emergency departments. These patients fill beds needed for new emergencies, and require considerable attention from nurses who are less available to care for new patients.

Expanded home care, and increased long-term care facilities, may keep the frail elderly in the community, and out of the emergency room. Or, we could reverse the long-term nation-wide trend toward reduced hospital beds.

These last solutions involve investing substantial additional resources in health care. That may be the right thing to do, but we should take care. It would be desirable to reduce inconvenience, and we would all feel better avoiding the occasional highly publicized horror story. But if that's all we achieve, the investment may not be worth it. ♦

*First published March 30, 2004 as one of Dr. Gordon Guyatt's biweekly columns in the Winnipeg Free Press.*

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# SUPREME COURT DELAYS DECISION IN IMPORTANT MEDICARE CASE

Brad MacIntosh

Canadians will have to wait until fall for the Supreme Court of Canada until fall to deliver a verdict in a case that cuts at the heart of Medicare.

The appellant is a Quebec doctor, named Jacques Chaoulli. His patient, George Zeliotis, has been riddled with various health problems requiring heart surgery and several hip operations. Chaoulli argues that excessive wait times for surgery violate the Charter of Rights and Freedoms, which guarantees life, liberty and security of the person.

Previous unsuccessful rulings in the Quebec, Ontario, Saskatchewan and New Brunswick courts, which ruled the collective right through universal health care is more important than individual rights, have not deterred Dr. Chaoulli.

The theory behind suing government is that rulings enforced by a court of law are likely to have a greater influence than individual citizens or citizen

groups that lobby the government. Chaoulli has taken his case to the Supreme Court as a last straw. His goal is the creation of a private parallel health system in Canada, the extent of which would be determined by how much an individual is willing to pay.

He also has the backing of various interest groups (like the Fraser Institute) and 10 Senators (notably Michael Kirby). Proponents argue that Canadians wishing to pay for independent health insurance, as an alternative to our universally accessible “single-payer” system, should be able to do so and would have faster services. Make no mistake; this case is legitimizing two-tier health care system.

If the Supreme Court rules in favour of Chaoulli, it would prompt the creation of a private parallel health care and put strains on the public system. Many agree that the predominant forces dictating wait times, prompting this case,

are equipment and human resource shortages. And a parallel health care system would certainly poach health care workers, at the very least.

It is true that a minority of Canadians have already found ways to access private health care services. Reports of individual patients electing to pay for surgeries in Europe or the United States appear sporadically in the media. In fact, Buffalo MRI & CT in New York State has a section of their website dedicated to “our Canadian neighbors”, with a standard MRI procedure quoted as \$465 US.

A recent editorial in the Toronto Star aptly describes this case: “Most people agree that Canada’s universal medicare system has major problems [concluding,] Declaring it unconstitutional, though, is not the cure” (Star, June 10, 2004 “In Defense of Medicare”). ♦

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## PFI’S: IMPLICATIONS FOR P3S IN CANADA – VISIT OF ALLYSON POLLOCK

Ted Haines

On June 1, the Ontario Health Coalition and McMaster’s Centre for Health Economics and Policy Analysis hosted a public forum by Dr Pollock at McMaster Health Sciences Centre. Her topic was Lessons from the UK National Health Service (NHS): The experience of P3 (‘Private Public Partnership’) hospitals. Her presentation at McMaster was one of several she gave in several Ontario cities and towns.

Dr. Allyson Pollock has extensively studied the impact on Britain’s health system of Private Finance Initiative (PFI) hospitals. She is the head of the Health Services and Health Policy Research Unit

at the School of Public Policy, University College London, and Director of Research and Development at University College London Hospitals Trust.

She began by arguing that public services matter. They redistribute income from wealthy to poor and redistribute benefits by sharing the risks and costs of services across the community and by delivering services on the basis of need rather than ability to pay.

P3’s introduce private sources of finance and create entry points for the private sector in infrastructure and supply of services.

In Britain’s Private Finance Initiative, consortia of builders, bankers, and service operators build facilities and operate non-clinical services. The NHS leases back buildings and services at a cost in excess of the costs of borrowing. The lease for buildings and services will last between 30 and 60 years and for land for up to 150 years. In addition, NHS is charged a facilities management fee.

For PFI hospitals, Dr Pollock has documented increases in capital costs exceeding 100 per cent in numerous cases. Costs increases are cov-

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## PFI'S: IMPLICATIONS FOR P3S IN CANADA (continued)

ered by the revenue budgets of clinical services, resulting in service reduction. Reductions in bed numbers at NHS trusts under PFI development are of the order of 30 per cent.

She cites a UK report (*PFI futures: capital investment after the white papers*): 'Each million pounds of incremental PFI capital costs anything from £100,000 to £170,000 a year, requiring the elimination of four to five jobs to pay for it. An incremental investment of £200 million requires 1,000 job losses, which might be significantly greater than 25 per cent of the work force and is probably only achievable by reducing the number of doctors and nurses, although often those job losses will not be realised within the hospital undertaking the de-

velopment, but in the local healthcare market.'

Financial privatisation introduces new inefficiencies and costs, including increases in transaction costs (pricing, contracting, administration, overheads, marketing, monitoring, billing), shareholder profits and bankers' interest payments.

She points out that it is difficult to monitor the true costs of PFI and that revisions to contracts and payments are often not provided.

Pollock ended with a citation from Alexander von Humboldt: 'The spirit of commerce, which gives rise to the esteem of wealth, also fosters a disrespect for all values and goods that cannot be bought for money ... One cannot want that the state of civilisation, the increase

in knowledge and humanity are measured as money value of exports or according to tonnage. Nations as individuals should not be judged upon according to a specific point in time, instead they come up to their mark going through a development according to their national character and their own physical conditions.' ♦

Click on <http://www.p3watch.ca/> to go to the P3 Watch web page. It is designed to be a repository for as much information on P3s in health care as we can get - news, research, fact sheets, resources, links, etc. In order to keep the information current, and to add valuable older material, please contact Mike Luff at <<mailto:mluff@nupge.ca>> mluff@nupge.ca or (613) 228-9800.

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## NO GOOD REASON TO ALLOW FOR-PROFIT INDEPENDENT HEALTH FACILITIES

**S**ujit Choudhry and colleagues are to be congratulated for raising the troubling issues of physician kickbacks and self-referrals.(1) We agree that these practices are ethically dubious and ought to be much more closely regulated.

One simple way to limit kickbacks and self-referrals would be to ban investor-owned independent health facilities from operating within the publicly funded health care system. Kickbacks and self-referrals exist chiefly to increase profit. Disallow profit, and these practices would likely wither away.

There is another reason to ban investor-owned independent health facilities—quality. In the United States at least, investor-owned hospitals(2) and dialysis centres(3) are associated with higher mortality rates than private non-profit facilities. In the Canadian context, for-profit independent

health facilities are most common in the diagnostic services (e.g., laboratory testing and imaging) and rehabilitation (e.g., physiotherapy) sectors. A priori, there is no reason to assume that the services they provide are as good as those provided by non-profit operators. As one highly respected health care analyst recently wrote in CMAJ, "Canadians [should] re-embrace the core concept of a universal health care system in which the vast majority of services are provided by non-profit institutions with public accountability."(4)

So yes, we should ban kickbacks and limit self-referrals. But if we really want to address the root of the problem (and improve quality at the same time), we should encourage policy makers to prohibit for-profit independent health facilities altogether. ♦

*Irfan Dhalla on behalf of the Medical Reform Group*

1. Choudhry S, Choudhry NK, Brown AD. Unregulated private markets for health care in Canada? Rules of professional misconduct, physician kickbacks and physician self-referral. CMAJ 2003;170(7):1115-8.

2. Devereaux PJ, Choi PT, Lacchetti C, Weaver B, Schunemann HJ, Haines T et al. A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. CMAJ 2002;166(11):1399-406

3. Devereaux PJ, Schunemann HJ, Ravindran N, Bhandari M, Garg AX, Choi PT et al. Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: a systematic review and meta-analysis. JAMA 2002; 288(19):2449-57.

4. Naylor CD. Your money and/or your life? CMAJ 2002;166(11):1416-7.

Letter published in March 31, 2004 electronic version of Canadian Medical Association Journal at: <http://www.cmaj.ca/cgi/eletters/170/7/1115#963>

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# THE NEW RED BOOK -- REQUIRED READING

Yves Talbot

This is a “must read” for all MRG members and people who care about our public health care system, Michael Rachlis’ new book will provide any advocate of our health care system with a compelling list of proven possibilities to improve wait lists, home care, drug availability, Primary Health Care and Palliative Care while using a preventive and patient-centred approach to planning and service delivery based on quality that will ensure the system’s sustainability.

In his initial chapters, Rachlis sets the stage. Crowded emergency rooms are like the canaries in the mineshaft, to use an expression of policy researcher Raisa Deber — they are a reflection of something going wrong in our system both upstream and downstream. How Ontario cost cutting resulted in a bottlenecking strategy, engorging emergency rooms during the flu epidemic while Western Canada had established strategies through regionalization, allowing them to weather the storm with much less trouble. This resulted in many newspapers in Canada and the US blaming our Medicare system and Toronto newspapers from left to right eager for reform.

How this came to be is the second chapter on the book, in which Rachlis reviews the development of our system and partial withdrawals of the Federal government, making our system a series of provincial systems with no end to the Federal-provincial battles. Our system’s focus on physicians and hospitals, where most of the care was provided forty years ago, represented only half of the vision of Tommy Douglas. The current deinstitutionalization of health care provision stresses the need to complete this vision, a vision supported, among others, by Justice Emmett Hall, John Hastings and Mme. Monique Bégin.

“The user fees were not going to be compatible with the Canadian way, which favours access. He [Hall] suggests that the feds take measures to eliminate these

practices. He also recommended some changes in the delivery system, including better Community Health Services and enhanced use of nurses.”

The following chapters present how various experiences have been able, within the current system, to improve the delivery system of primary health care, home care, palliative care, management of chronic illness, prevention and the interminable waiting lists.

Each chapter starts with a vignette illustrating the author’s point, providing information and data on the problem as well as how people have successfully developed innovative solutions, generally based on quality. Each chapter finishes with a set of questions allowing readers to evaluate the problems in their own community. This is a very effective presentation making issues clear to the reader. For example:

1. End of life in Canada and the experience of the Tammy Latimer palliative care centre and community based care which has supported many patients and families in Toronto.
2. Chronic Illness and the Group Health Cooperative in Seattle, Sault St Marie (diabetes) Vancouver (asthma) initiatives. These experiences all demonstrate how better management of chronic illness increases patients’ quality of life.
3. Home care allows for earlier discharge from hospital, prevention of hospitalization of the frail elderly or persons with mental illness. Examples were the Victoria Health Quick Response Team, CHOICE (Comprehensive Home Option of Integrated Care for the Elderly) in Edmonton and ACT (Assertive Community Treatment) in Ottawa.
4. Long-Term Care: the experience of Denmark the US and Sherbrooke Québec.
5. Public Health, “an evaluative conscience for clinical care system,” over the years has suffered important set-

backs. Ontario, in particular, has suffered with cost cutting and the privatization of water inspection as well as reduction of staff highlighted most recently by the SARS crisis. Little support was offered by the Romanow Commission on the Future of Health Care directly, yet innovation have been noted with the vaccination registry in Manitoba, Sherbrooke’s involvement with Healthy Cities, the diabetes program in Kah-nawake and Prevention and Harm Reduction in Downtown Lower East Side in Vancouver, to name a few.

6. Doctor shortage: Concern about life style and what to do about team care address some of the limitations in the current fee for service system with Dr. Do-Right and Dr. Make-Good. The new experiences of Saskatchewan, Québec, Taber Alberta, the shared care mental health program in Hamilton are highlighted. Deinstitutionalization as well as new technologies of care have increased the complexity of care needs patients in the community, and as a result more data seem to support the quality offered by team care.

7. Cost and Accessibility of drugs a major issue. Our health care system has demonstrated an important reduction in overhead cost through single payer system and a similar solution could be applied to drugs, along with better utilization of non-pharmacological treatments.

8. Wait times are an area where proponents of privatization have have been subject of especially scathing critiques from proponents of privatization. Rachlis describes how this is addressed by new wait list management and advanced ac-

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## THE NEW RED BOOK (continued)

cess techniques, as applied for example in Sault St Marie for primary care and breast cancer care. Better access can be achieved through team care, centralized waiting list and case management.

This compelling book will often leave you, like it did me, wanting to know more about each example used. An extensive bibliography of peer reviewed articles; government papers and websites will allow finding more about them. A question that I had was why haven't we heard more about these pearls. I suppose the old saw about newspaper headlines—if it bleeds it leads—should be followed by a corollary—when it heals, it trails. Who wants to hear about happy doctors and patients? We do and so do the Canadian people.

In his final chapters Rachlis demonstrates that privatization is not only not necessary but for profit cost more and may even be dangerous to patients. Rachlis draws from the US Veteran's Administration experience which is not as well publicized as it should be, and the recent transformation of the NHS to show how it is possible to create a seamless system for patients that is cost efficient and of high quality results. The reengineering of our system does not necessarily mean more money but better management. We are already spending almost 10 per cent of our GDP while other countries spend less with more comprehensive coverage and a larger proportion of public spending. ♦

*1 Rachlis also includes in appendix the US Veterans Administration plan-do-study-act cycle and Breakthrough Collaborative protocols of planning and management.*

Michael Rachlis MD, **Prescription for Excellence, How Innovation is Saving Canada's Health Care System.** Toronto: Harper Collins, 2004. 428pp. \$32.95

## MERCHANTS IN THE TEMPLE? IMPLICATIONS OF THE NAFTA AND GATS FOR CANADA'S HEALTH CARE SYSTEM

*Report of the Spring Members' Meeting*

*Janet Maber*

The role of trade agreements on the future of health care delivery has been an ongoing issue with the Steering Committee for several years now, and members were afforded an incredible opportunity to be educated at the spring meeting on May 12, 2004. Tracey Epps, Doctor of Laws Candidate at the University of Toronto reported on her Master's research on the North American Free Trade Agreement and the General Agreement on Trade in Services, and engaged members in dialogue on their implications for nearly 3 hours.

Epps set the context for her presentation on the potential for gains and losses to the provision of health care services in Canada by talking about the objectives of international trade liberalization, primarily:

- ♦ Free movement of goods, services, capital and people across borders through the elimination of barriers to the international flow of goods and services.
- ♦ Improvement of access and choice for consumers as exchange of goods and services is increased

In general, it is assumed that domestic laws and regulations can impede the trade in services, and so the most usual strategy has been to deregulate or otherwise eliminate or dilute the effect of protective regimes, such as those implicit [and explicit] in the Canada Health Act. This has been an issue of much debate since the beginning of free trade discussions a generation ago. Concerns have centred around the extent to which trade liberalization would undermine the public nature of the health care system, either by privatization with the admission of foreign commercial interests and/or

diluting the principle of access to medically necessary services.

Epps described how the Canadian system contrasts with that of the United States, where the health care system is largely market driven, and public funding is pretty much restricted to the elderly and the poor. She also noted that health care has changed since Medicare was enacted in the 1960s, with an increasing reliance on services that were not explicitly by public insurance under the Canada Health Act, for example, drugs, home care, and alternative medicine.

She noted that access to services need not be affected by a Canadian government contracting with a foreign provider to deliver those services. However, access can be affected where the market for drug coverage, for example, becomes dominated by foreign insurers who determine the terms of coverage.

Several recent proposals (for instance, the Senate report led by Senator Michael Kirby, and the Romanow Commission on the Future of Health Care) have proposed inclusion of medically necessary home care as a way to relieve some of the pressure on acute care services, as well as the integration of prescription drugs, a theme taken up by most of the parties in one form or another during the recent federal election campaign. At the same time, she noted the range of provincial 'experiments' in the contracting out of delivery of publicly funded services.

### **NAFTA**

The North American Free Trade Agreement (NAFTA) has as its major objectives the facilitation of cross border movement of goods and services and  
*(continued on page 8)*

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## MERCHANTS IN THE TEMPLE? (continued)

increased investment opportunugh harmonization of regulation between the signatories. Thus, the cornerstone of the NAFTA is that each country must treat investors, service providers, and financial service providers from the other signatories less favourably than it treats its own domestic entities in like circumstances in all the areas subject to the agreement, or not on the list of reservations.

The other important condition of the NAFTA is that a party may not nationalize or expropriate a foreign investment or take a measure tantamount to nationalization or expropriation, except, for a public purpose, on a non-discriminatory basis, in accord with due process and on payment of compensation (Article 1110). A number of reservations have been the subject of continuing debate between the parties, most of which continue to be complicated by the 'experiments' underway in most provinces.

In the definition of 'public purpose,' Canada has maintained that the key factor in determining this is government intent, whereas the US is of the opinion that the reservations only apply to services financed and delivered by government; in particular, where health care services are supplied by a private firm (whether for-profit or non-profit) the US believes they are not covered by the reservation.

The difference is substantial. If the Canadian government wants to prevent private insurers (including US companies who are already active in the Canadian setting) from providing insurance to cover drugs and home care because these services are covered by the provincial plans, it may have to pay compensation to the US insurers. In Canada's interpretation, publicly funded services provided by private providers are protected by the reservation. However, US interpretation would see such services subject to all the NAFTA's provisions, including national treatment.

Epps concluded the the values underpinning the Canadian health care systems are very different that those central to international trade agreements, and that the NAFTA negotiators appear not to have understood the implications of the myriad of public-private relationships and the changing dynamics of the health care system, as the Annex II reservation clearly does not protect any aspect of the health care sector that has been opened to private financing.

Epps sees two options for mitigating adverse effects of the NAFTA:

1. Negotiate the interpretation of amendment of the Annex II reservation on public purpose;
2. In view of the possible trade consequences, ensure that all legislation and regulation include the clear intention that publicly funded health care services are considered 'social services maintained for a public purpose.'

### **GATS**

The General Agreement on Trade in Services (GATS) is a framework and set of rules for trade in services among 146 member countries through successive rounds of multilateral negotiations. The provisions are enforced through the WTO disputes settlement mechanism which provides for establishment of disputes panels with appeals to an Appellate Body. The key provisions relevant to health care are summarized in two levels of obligations:

- ◆ General obligations that apply to all services
- ◆ Specific obligations that only apply to those services for which member countries have made commitments (in their "Schedule of Commitments").

Canada has made commitments on private insurance which would cover services such as drugs, vision care, dental care and supplementary home care and so would be obliged to extend most favoured nation treatment to all providers, so that for example if a British com-

pany is allowed to contract to provide home care services, companies from other GATS member countries must be allowed to do the same.

Epps noted an exemption to the GATS of 'services supplied in the exercise of governmental authority, neither on a commercial basis, nor in competition with one or more service suppliers.' In her opinion, although there is no jurisprudence on this provision, she thinks it would fail to protect most health care services provided in Canada. At the same time, she notes that compensation required in the case of the GATS is not financial and therefore not necessarily an obstacle to reform.

Moreover, negotiations to date have so far not included any proposals relating to health care, and it appears that none are likely in the near future. Indeed, Canada has been among the leaders in this area, with a position which Epps summarized as "preserv[ing] the ability of Canada and Canadians to maintain or establish regulations, subsidies, administrative practices or other measures in sectors such as health, public education and social services."

The GATS provisions with the most impact only apply where specific commitments have been made and to date that have only been made in private health insurance. The GATS **does** leave room for governments to regulate in the area of health and social policy. There seems so far, not much pressure from member countries to put health on the negotiating table. Canadian government is taking a position that is in the interest of the health care sector. Under these circumstances, Epps recommends maintaining the present course of action. ◆

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# DRUG MAKERS DECEIVE DOCTORS

PETER (not his real name) is a physician-scientist who, a couple of years ago, was finishing his research training in Canada. Shortly before returning to his native Australia, Peter received an interesting offer.

A pharmaceutical company was ready to pay Peter several thousand dollars to write an opinion piece for a prominent medical journal. Peter is smart, and a good writer. Producing the article would be a cinch. Attractive proposition, no?

Well, a couple of catches. First, Peter would have to follow the company's direction about what to say. Second, when the article was published, Peter's name would not appear.

Rather, a respected senior researcher who has conducted many studies funded by the pharmaceutical industry would get the credit.

Peter refused the offer. The company probably succeeded in finding a different, willing ghost-writer. Like all unethical practices, it is difficult to establish the size of the medical ghost-writing problem. Senior authors will never threaten their prestige by admitting someone else wrote their article. Professional ghostwriters won't embarrass their clients. People like Peter won't embarrass their colleagues.

Ghost writing is a big enough business, though, to sustain companies focused on medical writing. Medical editors recognize ghostwriting as a widespread practice and have tried to tighten up their rules. Still, there is no protection against misleading or dishonest representations, and authorities suggest that up to 50 per cent of articles reporting results of pharmaceutical trials are ghostwritten.

Lead authors of major drug studies may not only have done little of the writing, but their participation in the research itself may have been minimal. Company personnel may have developed the research plan, supervised the collection of the data, conducted

the analyses, and written the first draft of the article.

The companies then go to prominent researchers. "Would you like to be an author, or even the leading author, on the article?" they ask.

The higher the profile of the author, the better for the company. The author's prestige helps to establish the credibility of the study, and contributes to the attention that the article receives. While these extreme situations are not the most common way drug studies are reported, they merge into a grey area that is very common. Academic researchers may participate in planning the study and carrying it out, but they may never see the actual data. The company conducts the analysis, and presents the academic authors with tables that summarize the results.

A McMaster University researcher, P.J. Devereaux, has just completed a study comparing how medical scientists report their research, and what actually happens in their studies.

To carry out his research, Devereaux interviewed authors over the phone, asking them detailed questions about the conduct of their studies. One lead author of a study published in a top journal had little idea what happened. He informed Devereaux that the company had completed the study, analyzed the data and wrote the first draft of the article. He advised Devereaux to contact the company for further information about the trial.

On other occasions, Devereaux found that authors' knowledge was sketchy because their role in the planning, conduct and particularly the analysis of their studies was limited.

Such situations mean that academic authors may never see important information, or that the company may present results in a misleading way.

That helps to explain the findings of a recent study showing that the odds of industry-funded trials enthusiastically recommending treatment are more than five times as great as non-industry funded studies.

Biased presentations affect not only how individual doctors understand research results, but how experts who create guidelines understand the results. Worse yet, the industry exerts direct influence on those experts.

Investigators at the University of Toronto conducted a survey that included 44 guidelines designed to help doctors make decisions about diagnosis and treatment for their patients.

The Toronto researchers found that 58 per cent of guideline developers had received research funding from the industry, and 38 per cent had served as employees or consultants. Fifty-nine per cent had relationships with companies whose drugs were considered in the guideline they authored.

Whether they are recruiting ghostwriters, giving credit to academic authors while controlling the conduct and analysis of research studies, or providing generous funding to researchers, the industry's goal is the same. Having researchers and experts carry their sales pitch to the practising doctor enhances the credibility of the company's message.

The result is often poorer and less efficient patient care. Industry bias leads to overuse of medication, and particularly overuse of new drugs. Drugs that are recently developed and released are far more expensive. About 25 per cent of the time, these new drugs turn out to have serious side effects that are not suspected at the time they were released. On occasion, these side effects are fatal.

Doctors expect objectivity in the research reports and expert recommendations that guide their practice. Too often, the drug industry ensures that bias, rather than objectivity, is what doctors receive. ♦

*First published Tuesday, April 13, 2004 as one of Dr. Gordon Guyatt's biweekly columns in the Winnipeg Free Press.*

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# ATTACK PROVINCES TO SAVE MEDICARE

Paul Martin is hoping to win the upcoming election by girding himself in Medicare-defenders' armor.

But for Martin's Medicare defense to go beyond election posturing, his Liberal government must resolve a fundamental contradiction. Any serious Medicare revitalization will run afoul of the provinces.

The problem any post-election federal government will face is that several provinces have no interest in preserving the central principle of equitable access to health services. Quebec, British Columbia and New Brunswick have proved increasingly willing to let their citizens pay to jump the health care queue.

These governments allowed the expansion of facilities offering quick access to sophisticated diagnostic tests, particularly MRI scanning, for a fee. Those who jump the queue get quicker access to additional procedures, including surgery, that depend on MRI diagnosis.

This practice violates the Canada Health Act. But both provincial and federal governments seem to believe that if everyone keeps quiet about it, no one will notice. And so far, not many people have. But that may be changing. Alberta is the number one Canada Health Act violator, and its leaders are increasingly open about their desire to make sick patients pay.

Health Minister Pettigrew has acknowledged that Ottawa has been inconsistent and arbitrary in enforcing the Canada Health Act. Indeed, they've been so lax that the federal auditor has labeled their negligence, and Medicare advocates are trying to force more stringent enforcement through the courts.

Since he has confessed his government's incoherence in Canada Health Act policy, what is Pettigrew's solution? Involve the provinces. "Leaving the enforcement exclusively in the hands of the federal cabinet does not really guarantee us the best possible enforcement."

But isn't Pettigrew aware that sharing policy about health act enforcement with Alberta Premier Klein and his Health Minister Gary Mar will be handing the keys to the henhouse to the fox? Maybe that's his intent. For instance, Pettigrew has said that he's ready to discuss whether MRI is a necessary health service. That's a way out - just define a service as unnecessary, and you don't have to worry about queue jumping.

Other statements, however, suggest a different approach. "I think we should be developing, along with the provinces, certain mechanisms in which we would make sure that the Canada Health Act is implemented." Perhaps, rather than handing out the keys, Pettigrew wants to negotiate henhouse access with the fox.

Canada Health Act enforcement isn't the only area where the federal health care ship may founder on the rocks of provincial intransigence. Martin says he's ready to give more money to the provinces, but only if they agree to be accountable. Specifically, he wants to ensure adoption of Romanow report recommendations for national home care, prescription drug, and primary care delivery programs.

What's Gary Mar's reaction to that? He's not interested in a "rehash" of the Romanow recommendations. And he's got a point. A commitment to move toward national home care and pharmaceutical was part of the 2003 federal-provincial accord. So far, nothing has happened. The provinces have not taken their pledges seriously. The agreement had no enforcement mechanisms, and they know it.

The way the Liberals have handled the Canada Health Council demonstrates the consequences of their contradictions. A key recommendation of the Romanow report, the Council is intended to monitor the performance of the system, and ensure both federal and provincial governments fulfil their

responsibilities. But the provinces, particularly Alberta, tried to kill the Council.

What was the compromise? The Liberals established the Council, but have given it a puny budget, so small that it will be impossible for the Council to fulfil its mandate. Even the Council's hand-picked Chair, Michael Decter, is sufficiently irritated to make his frustration public.

"This thing is a little off the rails," said Decter recently. "The Council itself was to have been created in 90 days and took nine months, that's not a promising start if you're going to convince Canadians you're going to shorten wait times."

So, if Martin is serious about revitalizing Medicare, what should he do? History provides the solution. Back in the days when Liberal governments were ready to take action that was best for Canadians, they had to take some heat from angry provinces. When Lester Pearson first implemented Medicare, Ontario Premier John Robarts had this to say.

"Medicare is a Machiavellian scheme that is one of the greatest political frauds that has been perpetrated on the people of this country."

Unless Martin - or indeed, Jack Layton or Stephen Harper - are ready to get tough with the provinces, they can never secure Medicare against those who want to destroy it. Layton has made it clear that he will put Medicare above provincial autonomy, while Harper wants to hand the provinces more power. Exactly where Martin stands remains, for now, mysterious. ♦

*First published Tuesday, May 25, 2004 as one of Dr. Gordon Guyatt's biweekly columns in the Winnipeg Free Press.*

# WHY TRY TO FIX WHAT IS NOT BROKEN? (continued)

ernment actions in ways that are concrete and go well beyond vague “encouragement”:

- ◆ include a gender-based analysis of the impact of decisions;
- ◆ use the widely-accepted precautionary principle as the overriding measure for all decision-making;

◆ enshrine transparency and public access to all information about food and drug testing and government rulings;

- ◆ ensure that Canadian standards are respected in any international harmonization agreements and in the use of Canadian drugs outside of our borders;
- ◆ provide for full disclosure of data on adverse drug reactions;

◆ strengthen and improve enforcement of current limitations on direct-to-consumer advertising.

We look forward to hearing the results of the consultation and trust that the health and safety of Canadians will be a central consideration in any legislative proposals that you bring forward. ◆

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# WHY TRY TO FIX WHAT IS NOT BROKEN?

*Members may remember that in addition to the Commons Health Committee and the Senate Committee headed by Michael Kirby, this past winter the Health Protection Branch of Health Canada undertook a staff level review of health protection measures. In our view, the objective of weakening currently existing health protections is ill-conceived and the Medical Reform Group wrote the Branch to that effect on March 28, 2004.*

I am writing on behalf of the Medical Reform Group, a 25-year old association of physicians and medical students who are committed to the advancement of accessible high quality health care to all Canadians.

We are very concerned with the proposed health protection legislative renewal and remain strongly opposed to the underlying premise of this proposal, which is to replace the existing Food and Drugs Act with a new Canada Health Protection Act.

We believe that the Food and Drugs legislation currently in force is based on an ethic of public health and health protection. While current legislation could be far more effective with the addition of regulations that delineate clear enforce-

ment authority, it is nevertheless sound legislation.

The proposed replacement legislation appears to introduce industrial competitiveness and market considerations as factors to be considered in regulating food and drugs. This is clearly inappropriate in legislation that should have as its primary purpose protecting the health and safety of all Canadians.

In acting on behalf of Canadians, Health Canada has a duty to ensure that any changes to Canada's drug regulation system give clear precedence to health and safety over commercial interests. Specifically, legislation and regulations must:

- ◆ enshrine public engagement in decision-making and public scrutiny of gov-

*(continued on page 11)*

## PARTY TIME!!

Fall 2004 marks 25 years of the Medical Reform Group and the Steering Committee is planning another celebration. Provisional dates are November 6th or 13th in Toronto. Please let us know soon if you'll be available and if you have photos or other memorabilia which can be shared for the occasion.

To signify interest, please write us at [medicalreform@sympatico.ca](mailto:medicalreform@sympatico.ca), call at (416) 787-5246 or fax at (416) 352-1454.

## NEXT ISSUE

Watch for:

- PJ Devereaux on What We Have Learned from the Systematic Reviews;
- Irfan Dhalla on Boutique Medicine;
- Rosana Pellizzari on her Residency in Costa Rica;
- Living and Working with a Minority Federal Government

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