

MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

Medical Reform Group of Ontario, P.O. Box 366, Station J, Toronto, Ontario M4J 4Y8 (416) 588-9167

Volume 11, Number 1, February 1991

"MEDICINE IS POLITICS WRIT LARGE" – Rudolf Virchow

MRG Representatives meet with Ontario's new health minister

On December 6, three members of the Medical Reform Group's Steering Committee had a very cordial meeting with Ontario's new Minister of Health, Evelyn Gigantes. We had decided prior to the meeting to emphasize three content areas in our discussions with her, based on the discussion evening for the general membership held a few weeks earlier:

- the importance of maintaining and improving the quality of medical care in the province, while improving its efficiency to help control costs;
- the grave concerns that the Medical Reform Group presently has concerning covert extra billing, especially in certain specialties in Toronto;
- our particular concerns with the large numbers of disadvantaged persons not yet enrolled in the new Ministry of Health "health card" system, with the recurrent implicit threat by the Ministry that physicians providing care for these patients must assume the entire burden of enrolling them, and may be left without fee-for-service reimbursement if enrollment is not completed by a given date.

We began the meeting by outlining the basic MRG principles (equitable access to care, the broad social nature of the roots of ill health, and the need to reduce excessively hierarchical organizational structures in health care by democratization). The Minister had clearly heard something about our organization before and was very interested in these additional details. We then began discussion of the first con-

cern noted above. We noted the current financial pressures on the Ministry, but focussed on the need to improve the efficiency of health care in the province without compromising its quality. The Minister obviously appreciated our understanding of her situation, but did not allow us to wallow in generalities for very long. She soon had us brainstorming various possible strategies for reducing inefficiencies in the health care system – which presented something of a challenge to the three Steering Committee members present, since such specific policies have really not been fully debated by the MRG as a whole. However, we were able to point out some concerns around the proliferation of unevaluated new technologies for both diagnosis and treatment, as well as some of the aspects of fee-for-service general practice that lead to high volumes of dubiously necessary care (e.g. the tendency to "see" all colds and flus because one cannot bill for telephone advice). In terms of specific mechanisms for dealing with such issues, we praised the efforts of the Scott Task Force on the Provision and Utilization of Medical Services, and suggested that its efforts should be expanded to look at a wide range of clinical policy arenas where effectiveness and efficiency need critical evaluation. We also had a long discussion on the role of queues for rationing expensive health care resources, such as hospital beds, and the desirability of monitoring such queues to ensure that persons who really have more urgent indications for treatment are brought to the front of the queue promptly (as in the new coronary-artery-bypass triage systems set up in Toronto and elsewhere).

We then moved on to our concerns with covert extra-billing, which the Minister is also extremely concerned about. Indeed, she pointed out that she had fought long and hard in the House over this issue at the same time that the MRG had been arguing against a physicians' strike some years ago. There was general agreement that a detailed survey needs to be done to establish the extent and nature of all types of extra-billing at present in Ontario, and its particular burden on the persons least likely to be able to afford it: the elderly, single parents and persons on limited or fixed incomes.

On the subject of the new billing numbers associated with the "health card", the Minister indicated that action was being taken and that we would hear shortly about the Ministry's plans to improve this process, so as not to place an undue burden on either the practitioners serving disadvantaged populations, nor possibly risk interruption in services to them.

Finally, the Minister expressed great interest in receiving from us a list of members who have experience and/or expertise in a wide-range of policy areas. As you will see from the

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questionnaire enclosed with this issue of the Newsletter (see P. 6), such a list is in the process of being prepared for you by the Steering Committee, for use in a wide variety of applications.

The Steering Committee Members who met with the Minister left with the sense of a very positive session, and much interest on the Minister's part in continued dialogue with the MRG in the future.

John W. Frank

Rosana Pellizzari, Gord Guyatt, and John Frank met with Ontario's Health Minister Evelyn Gigantes on December 6.

Medical Reform

MEDICAL REFORM is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at \$25/year.

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

Correspondence should be sent to Medical Reform, P.O. Box 366, Station J, Toronto M4J 4Y8. Phone: (416) 588-9167.

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

Editorial Board: Haresh Kirpalani, Don Woodside, Cathy Crowe, Bob Frankford, Ulli Diemer.

Production by AlterLinks, (416) 537-5877.

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

1. Health Care is a Right

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

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

3. The Institutions of the Health System Must Be Changed

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

Letter faxed to the Prime Minister on Gulf War

Prime Minister Brian Mulroney
Ottawa, Ontario

Dear Prime Minister:

The Medical Reform Group of Ontario (MRG) would like to inform you of the heroism displayed by a Canadian citizen who is a member of the Steering Committee of the MRG. Dr. Robbie Chase has just joined the Peace Camp in Saudi Arabia. This Peace Camp is aimed at preventing a horrendous war in the Gulf at a time when many bellicose voices are raised. This type of heroism is usually not noticed, but deserves recognition.

The Medical Reform Group is extremely alarmed about the recent support by the Canadian Government to the Security Council resolution that authorizes the use of "all necessary means" including war in the Persian Gulf. This raises once more the cold reality of war, including possibly nuclear devices. The reality of war is injured, maimed and killed humans for both the armies involved and the general population. This must profoundly disturb all physicians whose mandate is to preserve meaningful life.

We see no compelling argument for war at this time. Specifically we would point out that: (1) In the Gulf there is every prospect of a successful blockade that will achieve the aims of an internationally agreed settlement of the crisis. (2) In recent precedents expressing international repugnance of a country's conduct, a realistic time frame for sanctions to exert their power has been adopted; the most prominent example being South Africa. Why has common sense been abandoned in the Gulf? (3) It would appear that the Canadian Government has been intent on following the lead of the USA. It should be noted that other nations have not been so anxious to spill blood in the Gulf.

We call on the Prime Minister to recognize the importance of the volunteers such as Dr. Robbie Chase, whose gesture in forming the international Peace Camp in Saudi Arabia should rekindle genuine efforts to avert war.

Yours sincerely,

For the Steering Committee of the Medical Reform Group of Ontario:

Dr. Mimi Divinsky, Dr. John Frank, Dr. Haresh Kirpalani, Dr. Andy Oxman, Dr. Rosana Pellizzari

Lively discussion of life under NDP government

Members of the Medical Reform Group met on November 27 to discuss the prospects for reform of Ontario's health care system under an NDP government.

The meeting was called to order by Gord Guyatt, who began by summarizing the topics and issues which had emerged from a previous discussion at the fall general meeting and at a subsequent Steering Committee meeting. Suggested questions to consider included:

- What are the priority issues in health?
- How can we work for the implementation of our policies under an NDP government?

Among the previously suggested priority issues were:

- Reducing the inequalities between physicians and other health care workers.
- Emphasis on high quality care in the most efficient way possible rather than on cost containment. Resist defining the issue as a choice between health care and other social programs.
- Democratization
- The dangers of privatization and extra billing.
- Encouraging more co-operation between the parts of the system, for e.g. between the Ministries of Health and Community and Social Services.

Tomas Ferreira opened the discussion with a comment that even with an NDP government, we have to be concerned about privatization. We need to keep private medicine out: look at what happened in the United Kingdom. It will start with small things. Another concern is expensive high technology and expensive and sometimes unnecessary treatments.

Michael Rachlis noted as an example the spending of hundreds of millions on completely useless tests and treatments for cholesterol. Social assistance reform or housing would have an amazing effect on peoples' health. We need to point out where money is being wasted. The government doesn't know

this, and it needs to know to make rational decisions. To have appropriate input we need to have an ongoing relationship with the government. Health Minister Evelyn Gigantes is being lobbied by everyone, and they all want more money.

Murray Enkin said it is very important that cuts be made in the right places. Across the board cuts will hurt the useful and the useless equally.

Tomas Ferreira said that we need to counter the drug detail men; educate doctors.

Susan Stock said that education is OK but it isn't enough. What action do you take?

Maritza Tennessee said this is very true in occupational health. Very expensive tests are being used which are ineffective.

Philip Hebert said that we should offer some perspective on process; on how health care spending should happen and be decided generally.

Mimi Divinsky said that the British Columbia Medical Association has set up a *pattern of practice committee* to talk with MDs whose practice doesn't fit the pattern.

Susan Stock said we should put occupational health on the agenda. A lot could be done in this area. E.g. jurisdictional difficulties between ministries of Labour and Health.

Michael Rachlis said that we should try to set up a meeting with the new Minister of Labour to talk about occupational health. We should establish a working group to do this. Also perhaps ask for a meeting with the Minister of Community & Social Services. One of the major problems of the government is that they are the government, but they aren't used to thinking like a government yet. We need to re-orient our thinking too.

Cathy Crowe said that this government will not necessarily be very different from previous governments. They need to hear the pressure on them to act.

Susan Stock said that there needs to be more funding from the Ministry of Health to do occupational health and community health centres.

Philip Hebert asked do we think there should be more spending on alternative forms of care, e.g. CHCs or HSOs?

Joel Lexchin said we should approach people in the minister's office or government and say so and so from the MRG would like to speak to you about such and such specific topic. Have a broader relationship with more people, don't just focus on the Minister. Also: give a pat on the back where appropriate.

Susan Stock said that we need to become clearer on some issues that will be coming up. We need to address what are the issues we think are really important, instead of just reacting to issues in the media or position papers that come up.

Gord Guyatt said the Resource Allocation Group has done some work on that.

Michael Rachlis asked do we have a clear answer to questions like 'Are you in favour of a 13% increase in hospital budgets?'

Gord Guyatt said that our position on that is that if cuts have to come they shouldn't be at expense of effective procedures.

Rosana Pellizzari said there are two issues. One is wages; the other is ineffective or inefficient care. Hospitals need to be reviewing what is effective. Doing that is a complicated process – how do you do it? Do you leave it to the hospitals?

Mimi Divinsky said a lot of decisions are physician decisions, not hospital decisions, e.g. how many gall bladders are booked. Is the government willing to confront the profession?

Philip Hebert said that we should suggest to the government that they work with physicians.

Susan Stock said we need to change incentives, remuneration. The reason a lot of ineffective things get done is because it's profitable to do them.

Philip Hebert: Also poor practice policies.

Tomas Ferreira said there will inevitably be clashes with some doctors who

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make a lot of money off these things.

Murray Enkin said that on some things there will have to be confrontation.

Michael Rachlis asked can we get involved in medical audit and quality assurance issues. We could be the 'left' in the debate rather than let the College or the OMA seem to be the liberals.

Miriam Garfinkle said that where specialists have extra charges, the issues is one of accessibility.

Gord Guyatt summarized by saying the

issues are maintaining effective care, occupational health, and process: facilitating an ongoing relationship and identifying people with expertise whom we can supply. Meeting with the Ministry of Labour on occupational health issues is a focus.

Minutes by Ulli Diemer

Abortion Law Policy

On December 1 and 2, the Ontario NDP Left Caucus held its policy resolutions conference on the University of Toronto campus. I was invited to speak to the afternoon workshop on Women's Rights issues and to make suggestions on the issue of abortion, that could be formulated into resolutions for the March 1991 provincial convention. Earlier that week Evelyn Gigantes, Ontario's new Health Minister, had announced new government policy on abortion - many wonderful things we had fought and hoped for.

Below is a summary of the items promised on November 27. They are followed by those things we would suggest as continued progressive policy to ensure women's choice and access to safe abortion. The most important and seemingly controversial issue is the provincial government's reluctance to declare the pending federal law (Bill C-43, which would re-criminalize abortion) unenforceable, as the Quebec Attorney-General has done. Such a declaration would reassure doctors in Ontario that they would not face prosecutions, a reason why many of them are even now, before the bill is law, refusing to do abortions.

November 27, 1990:

Abortion is a health issue, not a criminal act.

Free-standing abortion clinics will be fully funded.

Travel grants will be made available for women who need to travel to centres providing such care.

Efforts will be made to recruit and train physicians to provide abortion services.

Proposals:

Declare the pending Federal Law (Bill C-43) provincially unenforceable.

Put forward a "proposal call" for abortion clinics in under-served areas of the province. (Independent Health Facilities Act.)

Improve hospital care of abortion patients until such time as clinics exist throughout the province. i.e. fund counselling services; ensure that only 'dedicated' staff work with abortion patients; encourage the use of local rather than general anaesthesia; encourage the training of family physicians to do the procedure.

Consider a re-assessment of Dr. Marion Powell's "Report on Therapeutic Abortion Services in Ontario" (Jan/87)

Establish a 1-800 number that would provide information for women on the nearest access to service, how to apply for and receive travel funding, medical questions regarding the procedure, etc.

I would especially like to thank Nikki Colodny and Debby Copes for their help with this presentation and for their ongoing support and dedication to this issue.

Mimi Divinsky

The MRG and the crisis in American health care

On Wednesday August 14 Gord Guyatt and Rosana Pellizzari were in Boston speaking at the annual meeting of a group called "Health Care for All". This is a coalition of community-based organizations (disabled folks, poor folks, old folks, etc.) who believe that a universal single-payer system is a moral and economic necessity for American health care. The meeting was attended by approximately 150 people representing a very wide constituency.

The conference was interesting in that Massachusetts was one of the first states which passed legislation mandating employers to provide health care coverage for their employees. Generally, the plan is acknowledged as having major weaknesses, in that it provided funds without any control on their expenditure. The group now recognizes that universal access and a plan to control costs must go together. They have therefore shifted their focus to a single-payer plan.

Gord and Rosana were asked to educate the group about the Canadian system. As in prior visits to the United States, it is striking the extent to which Americans find it hard to believe that Canadians really don't pay anything at the hospital or physician's office, and that there is no way one can obtain superior care by paying. The MRG's message about the good things in Canadian health care was very well received. The highlight of the question and answer period was a question about the extent to which Canadians have controlled spending on high-cost high-technology items. Rosanna's reply began, "Boys will be boys, and boys love toys" was met with laughter, pleasure, and applause from the females in the audience.

It was again evident that by providing a progressive perspective on the Canadian health care system, and its implications for America, the Medical Reform Group can play a significant role. It is important to have a credible voice to counter-act the American Medical Association's campaign of distortion and misinformation about the Canadian system. Hopefully, the MRG will continue to contribute in this way.

Gord Guyatt

Book Review

Vera Ingrid Tarman (1990). *Privatization of Health Care: The Case of Ontario Nursing Homes*. Toronto: Garamond Press.

In *Privatization of Health Care: The Case of Ontario Nursing Homes*, Vera Tarman outlines key elements of the debate about privatization of health and social services. Focussing on the commercial provision of services and on Ontario nursing homes in particular, she untangles the tensions between service provision and profit-making, developing the case that commercialization of services is likely to jeopardize three crucial aspects of care: its quality, its accessibility and the accountability of providers.

Tarman describes the maze of institutional services for the elderly in Ontario and the rest of Canada and, building on a range of carefully researched materials (Ontario Hansard, position papers of such relevant interest groups as Concerned Friends of Ontario Citizens in Care Facilities and the Advocacy Centre for the Elderly, publications and reports of govern-

ment committees, legislation), documents the history of nursing homes in Ontario. More than any other province, Ontario has witnessed a steady increase in commercial nursing homes; by 1989, 92% of nursing home beds were for-profit and their ownership had become concentrated among a very small number of companies. Tarman notes the growth of public concern about these developments and tracks the nature of government involvement in the nursing home field. She suggests that, subject to scrutiny, government interventions have been largely symbolic gestures. Most recently, for example, she argues that the Nursing Homes Amendment Act of 1987 fails to address the fundamental tensions between provision of care and profit-making and fails to placate either the public or the nursing home industry.

This thoughtful depiction of the political and economic context of in-

stitutional care for elderly people provides useful clarification of the current picture of service provision and underscores the need for change. At a conceptual level, the broader debate about diminishing government involvement in service delivery is also clarified and, especially importantly, our attention is drawn to the limited capacities of governments to ensure equal access to good quality nursing home care. These cautions challenge us to be alert to new commercial interests forming in other fields of service, most notably in community-based care, and to ask ourselves whether frail elderly people's interests are likely to be best served by such developments.

The book is a valuable contribution to the literature; Tarman presents complex ideas and a large amount of information in a very readable and concise fashion. It will provoke our thinking as, along with other political and professional interest groups, we refocus our efforts in light of the NDP election victory and anticipate reforms in the web of long term care in Ontario.

Jane Aronson

Jane Aronson is an Assistant Professor in the School of Social Work at McMaster University.

OHIP Numbers

Is Access to Health Care an Issue for MRG Members?

In the past the MRG has been an outspoken voice reacting to practices in the health care system such as extra-billing and user fees which restrict access.

According to recent reports approximately 1 million Ontario residents have not yet applied for their Ontario health card. Reasons may include illiteracy, lack of an address to receive the mailing, or lack of information regarding the need for the new health card because they haven't read about it, or don't have a TV or radio to hear about it. In fact many Ontario residents do not even have an OHIP number for some of the same reasons. Many residents were not aware that they were eligible for premium assistance if they were poor. Furthermore, many people lose their OHIP number or it is stolen. This happens frequently when individuals are homeless and are forced

to stay in hostels or shelters where there is no privacy or a place to keep belongings such as ID safe.

Certainly the changeover system from OHIP numbers to the new Ontario Health Card has not been smooth and only recently did the Minister of Health table legislation which would ensure the privacy and confidentiality of material collected with the use of the Health Card. Unfortunately there has not been a full debate on the insurance plan. A glaring example is that no one appears to be addressing the issue of who is responsible for ensuring that all residents are informed of their right to have a Health Card and consequently the health care that comes with it. Nor is anyone ensuring that for those individuals who need assistance in obtaining a Health Card that help is available. Suggestions have been made by MRG members that Welfare

workers should help their clients get their Health Card. This is quite impractical. Not only are these workers extremely overworked, but recent increases in the number of welfare recipients are placing additional demands on their time.

The notion that someone else is responsible seems to miss the point. It takes three minutes to help someone fill out their Health Card form. A doctor's office or Family Practice Unit can be used as the mailing address to receive this number for the client and then be placed in their chart until their next visit. Assisting someone with yet another complicated bureaucratic form does a lot to build trust in the relationship. All health care workers, including physicians, are responsible to ensure that their clients have access to the system. We urge the MRG to recognize the implications for access to health care and the role of physicians in addressing this issue.

**Dilin Baker, Kathy Hardill,
Cathy Crowe**

Street Health Nurses

MRG Membership Survey of Experience/Expertise

Please indicate below any areas of experience/expertise you have, in which you are willing to give as an advisor to the MRG, government, or various public sector activities, acting in an individual capacity. (Tick as many as are relevant):

- 1. AIDS ☐
- 2. Community Health Centre ☐
- 3. Emergency Medicine ☐
- 4. Environmental Health ☐

Specify Area(s): _____

- 5. Native Health ☐
- 6. Occupational Health ☐

Specify Area(s): _____

- 7. Pharmaceutical ☐
- 8. Population Health ☐
- 9. Poverty ☐
- 10. Other/enlargement on above _____

- 11. Prevention ☐

Specify Area(s): _____

- 12. Private Practice: ☐

Fee-for-Service ☐

Capitation/HSO ☐

- 13. Public Health ☐

Specify Area(s) _____

- 14. Quality of Care ☐

- 15. Refugees ☐

- 16. Smoking ☐

- 17. Trans-(multi-) Cultural/
Medicine/Immigrants ☐

- 18. Utilization/Cost Control ☐

- 19. Women's Health

General ☐

Abortion ☐

Obstetrics ☐

Sexual Assault ☐

Violence (other) ☐

Other: _____

Name: _____

Address: _____

Telephone number: _____

Correspondence

MRG Membership Policy Questioned

To Whom it May Concern:

Recently I considered joining the MRG. My prime motivation being to work with the MRG as a voice of reform for the dental associations in Ontario. I also believed that the MRG would welcome an initiative in the realm of dentistry, thus broadening its platform. I soon found out that full membership was open only to physicians and medical students. As outlined in the membership brochure, my joining (and that of other interested non-physicians or non-medical students) would have to be as an associate

member. At first I thought this to be an outdated guideline, but after a phone call to the MRG and a look at the recent Medical Reform (where 74% of respondents to a questionnaire indicated that "the MRG should remain primarily an organization of physicians and medical students") I realized that this group does indeed need reforming.

As a dentist working in a community health centre and with reasonable experience in international health care, I feel confident about what I could bring to the MRG. Logically, one would think that a group intended to bring

about changes to the health care system would welcome support and offer full membership to any individuals with common ideals. This would enable the group to act in various capacities through a multitude of different experiences and contacts.

I am still interested in joining the MRG, but not as an associate member. I suggest the MRG consider opening its doors and offer full membership to all persons interested in working towards a more egalitarian health care system.

Sincerely yours,

Joel Mark Rosenbloom, BSc, DDS

MRG debated in Canadian Medical Association Journal

The ideals of the Medical Reform Group (*Can Med Assoc J* 1990; 143: 368-369) appear to be lofty, although I have to pause at the idea of an uninformed/inexpert "public" having a direct say in health care resource allocations, as I have to pause at uninformed/inexpert politicians doing the same thing.

I don't need a committee to tell me how to treat my patients; I have done my homework, and I know what I am doing. The same principles could surely be better applied in the same way to the distribution of health care resources but appear to be steadfastly refused by our bureaucratic bosses.

Regarding Bill 94, certainly it banned extra-billing, but the net result to patients was just plain unfortunate. Since Bill 94 passed, anyone in Ontario who want better or quicker treatment has to go to the United States and pay far more there than one would have to pay here via extra-billing. What a marvellous achievement! Thus, such "extras" have been pushed even further into the reserve of the rich.

Although I am not a socialist, I feel sad that the bottom-line effect of Bill 94 was to further disadvantage some of the less wealthy people in this province. Hardly a laudable effect. To perhaps misquote, "May the Lord protect me from the well intentioned but ill advised."

Thomas J. Muckle, MD
Director of laboratories
Chedoke Division
Chedoke-McMaster Hospitals
Hamilton, Ont.

[Members of the group reply:]

Dr. Muckle implies that physicians rather than the public should make decisions about the allocation of health care resources. Our disagreement is perhaps a difference in values. We place a high value on democracy. We also question whether physicians are best able to direct the allocation of health care resources. There is ample evidence that individual decisions made by physicians for individual patients do not result in an efficient or effective use of societal resources.¹ Indeed, given the rapid evolution and disarray of medical knowledge it is not surprising that many physicians find it difficult to keep up on their own and that often what physicians do is inconsistent with scientific evidence.² Furthermore, the effectiveness of most clinical interventions has not been properly evaluated; and, even when it has been, clinical decisions must take into account not only scientific evidence but also patient preferences.

As to the "bottom-line effect" of Bill 94, it appears that Muckle has not done his homework. There is no evidence of which we are aware of a massive flow of patients to the United States after the passage of Bill 94 or of low-income people being disadvantaged by the banning of extra-billing. If such evidence exists we would be most interested in seeing it. More important, user fees and extra-billing do deter low-income people from obtaining necessary services.³⁻⁶

We do not advocate uninformed decision-making. Decisions about the allocation of health care resources should be well informed, regardless of who decides. However, we argue that an open and democratic process and the appropriate use of scientific information, rather than unfounded asser-

tions based on ideology, are the best protection against poor advice.

Andrew D. Oxman, MD
Donald Woodside, MD
Gordon H. Guyatt, MD
For the Medical Reform Group of
Ontario

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Primary Care, NDP government main topics at MRG General Meeting

The Medical Reform Group's Fall General Meeting took place October 13, 1990 in Toronto.

Financial Statement: The financial report was presented by Fred Freedman. It was suggested that we look into how the GST may affect us.

Steering Committee Report: The Steering Committee report was published in the last issue of the newsletter. Haresh Kirpalani reported on media activity. The Steering Committee feels that we should be more pro-active in seeking coverage. There was a discussion about media access to MRG meetings. A motion was passed that **Steering Committee decide what part of meetings be open.** Gord Guyatt noted requests for speakers/resource people from American groups interested in universal medical insurance. He feels this is a useful role and will increase. He will continue to be a contact person and will channel requests to other interested members. Regarding media coverage, Joel Lexchin said it is generally better to write an article than a letter (unless you are Philip Berger or Eugene Forsey).

College Guidelines: Joel reported on task force on relationship between pharmaceutical industry and profession. Dr. Brian Dingle chair. Suggested guidelines will be sent to 40-50 groups. Encourage comments from physicians and groups who want to restrain detailing and sampling. Rosana will complete a submission on what is being proposed in cooperation with Gord. Bob James made group aware of drug company sponsored dinners and 'educational' events.

Annual meetings: Andy suggested a change in format. Discussion re: more meetings or only one a year. Possibility of a meeting in Hamilton.

Other business: Mimi presented gifts to departing steering committee members Bob Frankford, Bob James, and Don Woodside and expressed good wishes.

Discussion of MRG under NDP government

Bob Frankford was introduced as the new parliamentary assistant to the new Minister of Health. (applause)

Don Woodside asked if the NDP has a health agenda.

Fred Freedman cautioned that people should remember that many in NDP are naive.

Gord Guyatt: Prior to elections, we polled all three parties re: health issues and NDP response was congruent to our MRG positions.

Joel Lexchin: The government may be a minor player vs. the bureaucracy on making policy changes. MRG should choose priority issues we want to see movement on, and then strategize.

Haresh Kirpalani said that he was concerned about the history of democratically elected social democratic governments in making cuts which would have been intolerable under a Tory government. We need to be vigilant.

Michael Rachlis suggested an income cut for physicians to protect those most vulnerable to the impending recession. We should voice our concerns re: health costs. MDs used to take 6 per cent and now take 10 per cent of total costs. Although we as a group are wary of suggesting health care cost cuts, 5 - 10 per cent of GPs are billing more than \$300,000/year and since CPSO/OMA are not making public stand, we must advocate for poor and disadvantaged and police the exploitation by MDs. We could make the physician community more responsible in their use of public resources. Maybe we need utilization caps, maybe we need caps on high billers. We could also educate the public that there are lots of MDs providing care to people who really need it and aren't reaping high incomes.

Don Woodside said doctors should not only NOT ask for a raise but we should take a cut. Also worried about privatization of health care - not sure whether NDP will do anything about hospitals deficits. With Independent Health Facilities Act we need to plan and discuss how primary care will be delivered.

Bob Frankford thought the government would take a strong stand against people going to the USA for treatment.

Bob James said that we need to support CPSO in battle (with OMA) re: quality control and quality assurance. Also, in response to Don, in looking at income issues, I make about \$45 - \$50/hr. and not sure that's too much.

Michael Rachlis: the traditional way that government deals with MD incomes is to stall or impose inadequate solutions. We can see what the *real* reforms and *real* inadequacies are. We, as MDs can make the criticisms.

Mimi Divinsky said that it could be dangerous to correlate high volume practice with bad medicine. Therefore we need to be clear and have good evidence.

Miriam Garfinkle said there are two arguments: (1) income, (2) quality of care. We can say that high incomes are unethical but argument is problematic. Therefore, better to focus on latter.

Rosana Pellizzari: However, the public perceives us as earning too much and we need to respond.

Gord Guyatt: Quality of care issue does include many factors such as inequalities, technology, resources. Therefore will pull together many of the issues we're discussing.

Primary Care Working Group Presentation

[See the September and October 1990 issues of Medical Reform for background information on the model being proposed by the Primary Care Working Group].

Bob James: Primary Care Work Group has been working two years on definition/structure of primary health care and its delivery. We have developed new models to combine clinical, population and research aspects which are politically possible.

Fred Freedman: The objective is to discuss and revise model. Hospitals have been excluded. Model hopes to democratize health services but allow diverse practices and remuneration (so as not to choke initiatives).

Steve Hirshfeld: What is definition of problem? Therefore what is the model

addressing?

Fred Freedman/Joel Lexchin: The model is addressing:

1. Need for democratization/politicization
2. Quality of care, currently no Q.A., no feedback, poor CME
3. Need to identify unmet community needs and a mechanism for implementation
4. Means to plan for and co-ordinate ancillary services.
5. Creating better network between primary care and consultants.

Miriam Garfinkle: Will it cost less?

Fred/Joel: We identified the need to evaluate the model late in its planning.

John Frank: There would be a variety of outcome measures.

Robbie Chase: Bringing organization/decision-making re: health services to OHC is a major step. If that could be implemented, then HUB model would naturally develop. Also predict that local health issues which are controversial, will become more polarized and publicly debated, e.g. planned parenthood etc.

Fred Freedman: Envision that C.O's will still be independent enough to respond to some of these controversial issues.

Steve: My experience teaches me that communities will want more power than just an advisory committee in order to buy into the model.

Don Woodside: I'd like to challenge the commitment to democratization at OHC level. School Boards not effective, therefore more likely to get democratic input at provincial level, i.e. M.O. Health. Policies never discussed trustees find discussion too risky and too divisive.

Further Discussion on HUB (afternoon)

Catherine Oliver: Concern re: too much local control and possibility of special interest groups to gain control e.g. Right-to-Life groups. One way to prevent is by mandated programmes to assure provision of services by OHC's.

Robbie: Also concerned about possibility of small town and Native communities being part of 1 DHC and potential for underrepresentation

Haresh Kirpalani: Re: school board model. If you have confidence in the population to understand issues, then you can place issues before them,

therefore need for widespread democratization. Doesn't see the threat of special interest groups as a problem since it will serve to mobilize counter groups in an open, representative system. One can transcend problems that school boards are currently experiencing. He cited Scandinavia and England where population practice some local control but could be expanded.

Don Woodside: Re: democratization: Progressive political decisions usually occur centrally. Danger at local level for economic structure to dominate decisions making. Therefore faith for decisions made at provincial level. What if there were two closely located DHC's which offered different services? - May cause major migration for utilization/accessibility. Reduction of inefficient procedures in one DHC, and not another, would be difficult.

Robbie Chase: Need to address socioeconomic determinants of health, both at HUB level and at macro level. How would that occur?

Fred Freedman: Democratization vs. progressive policy. Local control is more democratic, i.e. means are more important than the ends. Although short term gains may be slower or more tenuous, the long term benefits would be more lasting. Also, re: the crossing of boundaries: perhaps an exchange of services may take place to account for cross-over by residents.

Haresh Kirpalani: Bottom line is to trust the people and help them make the decision.

Bob James: Are there other possibilities to democratize the health system, for e.g. public health department?

Haresh Kirpalani: Democratization could take place at even more grassroots level, as long as representatives are accountable.

Miriam Garfinkle: Can understand Don's concern about present Board of Education model. However, we should examine how to integrate and involve people at neighbourhood/family level. Also suggest that CME include education for community

Steve Hirshfeld: Of course, system should be democratic, but it's open to abuse. Therefore crucial to raise awareness and education of the public.

Bob James: How could HUB and local MDs interface in community, e.g. share information such as level of immunization, current health issues?

Joel Lexchin: How to draw in below-

standard MDs?

Fred Freedman: In return for HUB's intrusiveness, offer incentives and benefits.

Gord Guyatt: Audit and feedback are the best methods to change physicians' practice and needs to be put in place.

Joel Lexchin: When seen as educational, rather than punitive, it would be better received. Physicians and liaison officer would have to implement.

Gord Guyatt: Those decisions are probably best made at the College level, where research is best conducted and expertise exists.

Joel Lexchin: Standards can be done at MOH provincial level, e.g. Rx for HTN. But physicians at HUB could decide to audit how they are doing.

Miriam Garfinkle: News that CME doesn't change practice. Patients not critical re: diagnosis and Rx - but hours, accessibility, communication. How will physicians be held accountable for these issues?

Joel Lexchin: Interpersonal communication harder to deal with than hours. HUB will coordinate on call. This should decrease popularity of walk-in clinics and house call services.

Miriam Garfinkle: Hypertension model a curative approach. Hopefully the role of HUB will be more preventive health. Good preventive health measures will become standard but will take time. Some doctors don't even do pap smear; some facilities never overdo high tech.

Bob James: A proportion of kids vaccinated, or pap smears.

Fred Freedman: Liaison officer could come in. It would be radical for someone to come in and ask how are your immunizations this month?

Joel Lexchin: Computerized data would tell you what proportion of women are getting pap smears.

Haresh Kirpalani: There are places in 'backwards' Britain where GP's over-using drugs will be audited; rates of childhood immunization are scanned. There are maximal feasible work loads worked out in conjunction with British Medical Association.

Rosana Pellizzari: That number will vary with population. I am worried about enforcing unrealistic standards.

Steve Hirshfeld: Voluntary compliance achieves little in employment equity. A goal could be established on joining HUB as a physician that 80% of women have paps.

Joel Lexchin: Physicians need to see it

as education not punitive. 'How can we solve this problem?' HUB could communicate by mail or phone with patients falling behind in immunization.

Don Woodside: What is role of democratization in applying technical standards of care?

Miriam Garfinkle: HUB can do outreach to workplaces.

Catherine Oliver: How can this work within fee-for-service? How do doctors know who is a regular patient to call people in for pap smear?

Haresh Kirpalani: It's much easier in capitation system.

Fred Freedman: We are opposed to fee for service as it presently exists. Is this the time to propose a timetable toward capitation? Health cards will allow patient follow-up.

Joel Lexchin: In primary care working group, we didn't want to call for abolition of fee for service; but that those who wanted to join the model would opt for capitation.

Bob James: Trying to get data from a physician office and a liaison officer going into physician office will be seen as intrusions.

Fred Freedman: Crucial that this not be done in a bureaucratic way. The liaison officer could be seen as a Big Brother. I'd rather stay the way we are than that.

Gord Guyatt: We have to deal with it. Things have gone terribly wrong in U.S. Nurses monitor if physicians have made appropriate admissions – major hassles. Has reduced admissions to medical school per one place. Government intention to have inspection for Independent Health Facilities Act led to outrage by doctors so they mandated CPSO to set standards for Independent Health Facilities. CPSO wants the experts to be persuaded to set standards based on evidence not practice. The top guns still use their expertise not scientific evidence. It is important for profession to do it, though they may only do it if they have to, to forestall a government intrusion. The role of liaison officer needs to be delineated.

Fred Freedman: Liaison may be a coordinator. Process of monitoring of physicians behaviour should be perceived as derived from and implemented by peers.

Steve Hirshfeld: Those being evaluated need some input into the standards chosen and how it will be monitored. At LAMP we were asked to set criteria for

good health care, and we did so.

Joel Lexchin: Liaison Officer shouldn't be seen as someone from OHIP or government. So shouldn't be feeding back information to OHIP. Not doers but co-ordinators. Help physicians with methodology questions.

Robbie Chase: I saw Liaison Officer as someone who brings community issues to the physician, not a policeman. Can feedback health utilization data to the practitioner.

How would your own practice fit into this model?

Rosana Pellizzari: My questions: 1) If major determinants of health are not health care where does housing and unemployment fit into this? 2) What is to prevent an oversupply of physicians? What mechanism will address supply of physicians?

Fred Freedman: We aren't going to deal with non medical determinants of health. I can see social services feeding in via Public Health.

Gord Guyatt: It offers more power to DHC, more democratization of DHC, moving to capitation, more quality control, and use of integrated information systems to provide feedback and quality control.

Robbie Chase: Problem with separation between social assistance and health care. The social planning research council would like more sharing of goals. This mechanism allows feedback of health indicators on a population level.

Rosana Pellizzari: What kind of information are we going to collect? How to protect confidentiality? I have little knowledge of DHC? I'd like to know how they work. We could present that model to get feedback. We need feedback on public health role.

Steve Hirshfeld: I'd like this group to consider role of nurse practitioners and cutting back on number of GPs. I could see 3-6 nurse practitioners and 2 GPs.

Fred Freedman: Implication would be closing a medical school.

Miriam Garfinkle: I'd be concerned about the choice issue: where would abortion services fit in?

Various people: DHC might not fund them at all or HUB could have them. May need provincial standard.

Miriam Garfinkle: I'd find it very corruptible.

Gord Guyatt: Are there dollars which will be divided between primary and tertiary services or social services? If we accept a fixed limit we'll be in trouble. There could be competition between health care and social services. As someone who sees waiting lists for hip fractures, cataracts, neonatal ICU, we could see worse problems competing with health or non-health services. I would lobby, and I would win – because people can envision a lack of surgical or hospital facilities and won't tolerate it. It's easier to constrain hospital spending at provincial than local level, even when they are not needed. Stressing primary care may cause a loss in financial resources.

Mimi Divinsky: Does this impact on the personal doctor-patient relationship? Is preventive care like flu shots so difficult?

Don Woodside: Patients would like it if it offers better network and upgrading without threatening the doctor-patient relationship. It offers costs at first but cost saving if it reduces number of doctors and specialists.

Catherine Oliver: Main problem is prevention of bureaucracy! (much agreement).

Gord Guyatt: Escalation of administrative costs in hospital is an example. Hospitals now starting to hand over fiscal responsibility to departments and it's more efficient. If at all possible, don't insert new people but overburden people already in the system.

Don Woodside: If more MDs on capitation, would they naturally evolve into HUBs? Would it be better to push the system of remuneration as a way or producing a better primary health care system?

Haresh Kirpalani: Are you, in fact, just producing a model which is a spin-off of HSOs?

Fred Freedman: HSO would not necessarily lead to health promotion and disease prevention.

Gord Guyatt: How would HSO lead to better preventive services?

All agreed: HSO does NOT reinforce health promotion and disease prevention.

Gord Guyatt: We can't afford fee for service and we want a system to monitor quality control.

The meeting thanked the Primary Care Working Group for its excellent work. They have been asked to come back with the results of these discussions in mind.

Renew your membership!

Although we are well into the new membership year, some members still have not renewed their memberships. If you are one of them, you will find a renewal form enclosed with this newsletter. Please send in your renewal now, while you're thinking of it! The MRG's ability to play a significant role in affecting developments in the health care system depends on having a committed membership, as does our financial viability.

Fees are \$175 for physicians, \$50 for residents and out-of-province (affiliate) physicians, \$25 for students and associate members, and \$50 for organizations. A subscription to the newsletter is included in your membership; additional subscriptions are also available for \$25.

If you have any questions about your membership, contact (416) 588-9167 or write MRG, Box 366, Station J, Toronto M4J 4Y8.

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MRG Policies

The policy resolutions which the Medical Reform Group has adopted through the past twelve years have been newly collected into a policy booklet. A copy of this booklet is enclosed with this newsletter.

Spring meeting on democratization

Plans are being finalized for the Medical Reform Group's Spring General meeting.

The main topic of the meeting is to be democratizing the health care system, with discussion focussing on models for instituting democratic control.

Probable dates for the meeting are April 20th or April 27th, but the exact date still remains to be finalized, depending on the availability of speakers.

Speakers confirmed to date for the meeting are Dr. Fran Scott and Michael Hurley, the president of the Council of Hospital Employees (CUPE).

More details in the next issue of **Medical Reform** or by calling the MRG's number: (416) 588-9167.

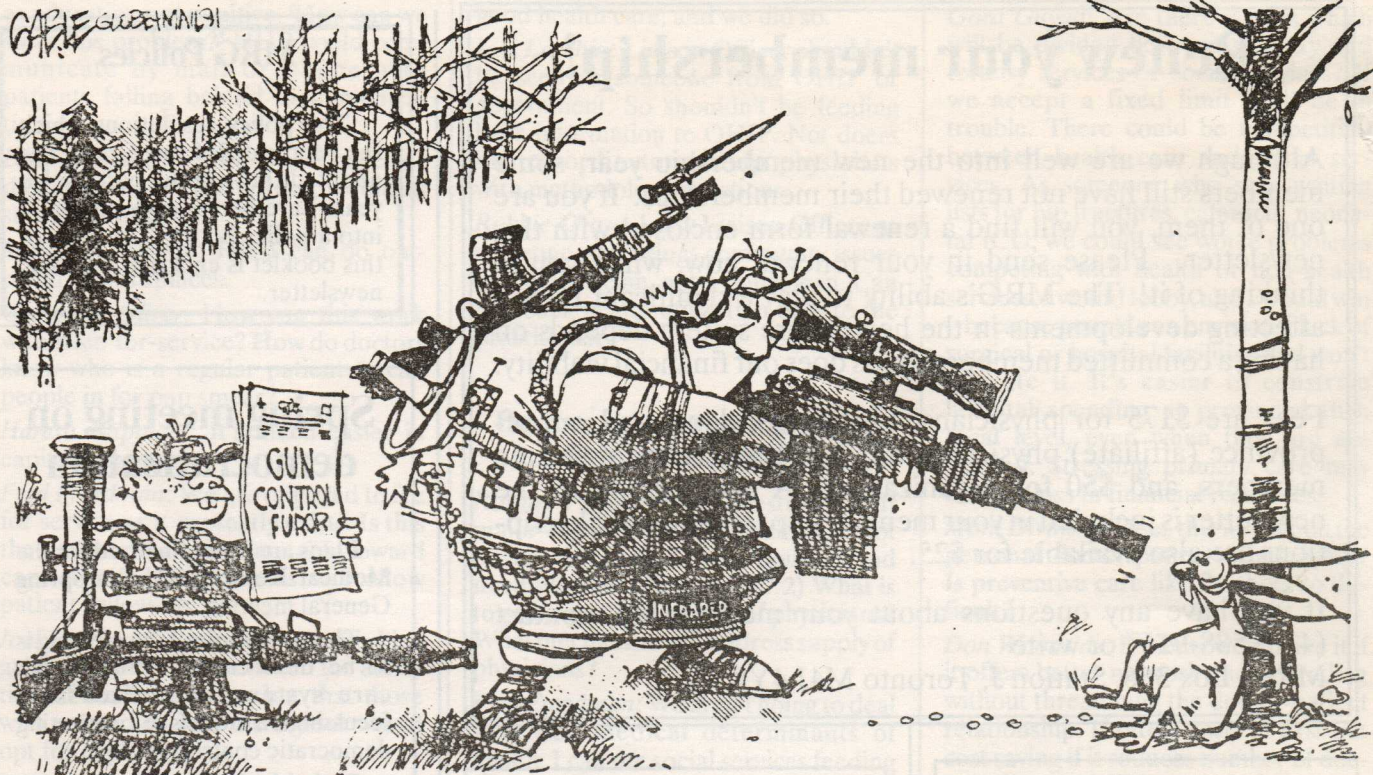
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