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THE MRG MAGAZINE

PUBLISHED BY THE MEDICAL REFORM GROUP OF ONTARIO

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Editorial:

Disappointment, Hope— And the MRG Magazine

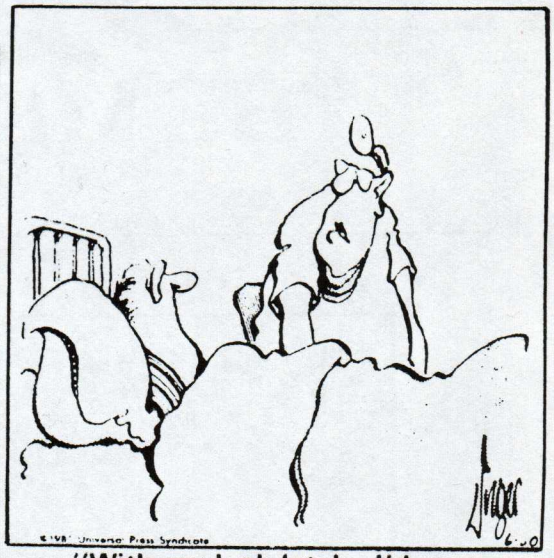
by Gord Guyatt

At the last general meeting of the MRG in May of this year there was a feeling among some members that the condition of the organization was serious. The patient, an infant barely two years of age, was suffering from failure to thrive. Those making this diagnosis pointed to the apparent decline in membership, a sense of exhaustion among those who have worked so hard for the group, and a lack of tangible accomplishments. Despite previous meetings addressing the question, "Whence the MRG?", there remained a lack of clear priorities.

Not all was gloom, however. Those less despondent pointed out that by many standards, the patient had behaved as quite a precocious infant. The MRG has established itself, in the press and in the minds of numerous organizations and individuals, as the voice of progressive physicians in Ontario. Starting with the efforts which culminated in the excellent presentation to the Hall Commission, work groups have continued with carefully researched policy papers. This has led to the establishment of a sound base of policy on general health care, women's issues, and the environment from which the steering committee has drawn for statements to the press and public.

There have been many direct, real world applications of our principles. The best example is the efforts of the Toronto and Hamilton occupational work groups whose members have served the labour movement as educators and sources of information. The founding of the Workers' Occupational Health Centre in Hamilton represents a major development in the occupational health scene in Ontario. On another front, the community health centres group has been working closely with a committee of citizens fighting for a health facility in Hamilton's east end. If the citizens win, the result will be a centre whose founding principles and practice will be based on conclusions and recommendations from the community clinics work group's brief to the MRG.

However, even those who pointed to past growth acknowledged the present problems. The excellent brief from the London MRG clearly delineated the difficulties and challenges for the future. Those at the meeting responded with a number of resolutions. These included plans for biennial two day meetings with both educational and business aspects and geared specifically for members from outside the Toronto-Hamilton axis. The focus on a single theme, the funding of health care in Ontario, was established as a priority issue for the MRG in the immediate future. Plans were made to look into various sources of funds which could be used to hire a full time person to fill various administrative, organizational and research roles for the group. Finally, the need for a publication which would be a forum for sharing the skills, knowledge and accomplishments of MRG members was identified. Hence, The MRG Magazine.



"With my luck lately, I'd say your chances are about 50-50."

At the May meeting, I took on the job of getting the magazine together, and would like to share the goals I see for the publication. It would be useful to see ideas about MRG directions committed to paper for the careful consideration of all members. A draft paper suggesting essential goals for the MRG, as well as discussion of some of the prominent issues which will be presented at the general meeting in October, are included in this issue. Secondly, results of the work of MRG members both within the group (such as the community health centres paper), and in associated activities (papers describing the Toronto Occupational Health Resources Committee and Toronto's Health Advocacy Unit) will make up a significant portion of the content. Thirdly, papers from outside the group which are educational and which stimulate critical thinking and debate about both our own and other health care delivery systems will be solicited. The description of health care in the new Nicaragua has been included with this in mind.

The MRG Magazine will be delighted to consider other ideas about its content, and will be on the lookout for articles, long or short, amusing or serious, from the membership. In the end, the magazine will hopefully contribute to a healthier, more sprightly MRG.■

Subscriptions

Continuing subscription to *The MRG Magazine* can be obtained by joining the **Medical Reform Group of Ontario**. Membership fees are as follows: Organizations $50; Graduate physicians resident in Ontario $45; Graduate physicians resident outside Ontario $25; Medical students $20; non-physicians $10. To join the organization or for further information please write to the **Medical Reform Group of Ontario**, P.O. Box 366, Station J., Toronto, Ontario, M4J 4Y8.

Healthcare in the New Nicaragua

by Robert Martin

(reprinted from the N. Y. Guardian, Dec. 31, 1980.)

A year and a half after the Sandinista victory in Nicaragua, reconstruction of the healthcare system is well underway.

The sense of human devastation apparent at the time of the revolution's triumph in July 1979 has been eradicated. New projects and a central health ministry have been established. International aid, particularly important given the lack of trained medical personnel and money after the revolution, has been secured.

When the Sandinistas made their march into the capital, Managua, Nicaragua faced a healthcare crisis. The effects of decades of neocolonial underdevelopment, combined with the ravages of war, had left their mark on the Central American country's 2.5 million people.

It is estimated that tens of thousands were injured during the struggle against the Somoza dictatorship. Many others still needed treatment for injuries caused by the earthquake of 1972. To these problems were added the constant stresses of high malnutrition (estimated to affect 67% of the children), tropical diseases (one out of five patients seen in the months after the victory had malaria) and the unavailability of any modern medical care to roughly 80% of the people. Moreover, roughly half of the hospitals and health centres were damaged or destroyed in the fighting.

Emergency Medical Teams

In the first week after the Sandinista triumph, emergency medical teams from Cuba and Mexico arrived in Managua. Since hospitals were destroyed, military tents were used to establish field hospitals at central sites.

Before the revolution there were four separate ministries which oversaw the health system and about a dozen, mostly small, health insurance plans. Thus, the first task was to take over private insurance plans and centralize the healthcare administration within a single national health ministry. Within the first two months of victory this was accomplished and the new ministry of health, MINSA, got active.

Then there was the problem of medical personnel. Although some of the country's 1400 doctors left with Somoza, more who were forced into exile during the dictatorship returned home after the revolution. Despite this return and a tripling of the class size at the country's medical school this year, Nicaragua suffers one of the lowest doctor-to-population ratios in the hemisphere, about .6 per 100. Worse, only 500 of the country's 2500 nurses are fully qualified.

For the time being, the country is relying on international help through medical teams which have come from about 15 countries. These health workers, numbering about 1000, provide care in remote parts of the country while Nicaragua reorganizes and trains its own personnel.

To build a doctor-centered system would have been so expensive as to doom the majority to an indefinite wait for health services. Instead, Nicaragua is incorporating the experiences of other societies to learn how to utilize other health workers.

First, nurses and nursing auxiliaries are expanding their roles. Since these are the majority of the health workers in the country today, they staff many of the primary health centers being set up in the rural area. In addition, they provide most of the backup for health campaigns and public health education.

Second, irregular health workers, most important midwives or grannies, are being included in the official health system, retrained and sent out to their communities to assist in childbirth.

Third, half a dozen types of health technicians and auxiliaries, from statisticans to dental assistants, are now being trained for the first time in Nicaragua.

Fourth, there is the health brigadista. Originally, the health brigadista was a literacy worker who, with other urban youth, spent five months in early 1980 living in rural areas teaching the peasants to read and write. The brigadista, though, had an additional responsibility: he/she was the one literacy worker in 20 who received a week's basic training in sanitation, nutrition, tropical diseases and public health. This person was charged with attending to the health needs of the other literacy workers in the group and, when possible, to the campesinos of the area as well.

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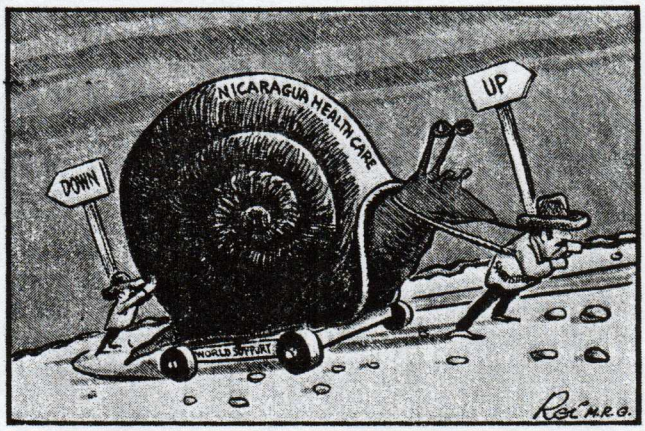

First Medical Contact

The health brigadistas blanketed the country with what was for most people their first contact with modern medical information and attention. They are now being retrained in a 3-month course and will return to the villages to provide ongoing basic care and health organizing. Their professional backup is the nurse at a rural health post. The nurse, in turn, can refer patients upward to a clinic or hospital staffed by a doctor.

Even such a basic network as this has phenomenal startup costs. Although health takes 17% of the national budget this year, most of the funding for the new health projects comes from foreign governments, international agencies, and solidarity groups. Especially because the government has refrained from nationalizing business and industry, this international assistance is essential to raise capital.

This policy of combining national planning and direction with international assistance is an innovative and key component of the Nicaragua development strategy. If it is successful, it will provide a lesson to many other countries.

The role of doctors in the coming years has not been fully clarified, but certain guidelines have been established. Those physicians working for the national health system are required to provide at least six hours of work daily, up from the 2-4 hours per day before the revolution. There is, however, no requirement that doctors give up private practice. Likewise, there is still a private pharmaceutical manufacturer, some private clinics and a private hospital in the country. This is consistent with the policy in productive sectors, which permits private interests to exist alongside public enterprises.

All new graduates of health training programs must provide two years of public service, but if they so choose they can then work privately.

Even though most physicians are working with motivation and commitment, grumblings can be heard about changes in the health system. And some doctors are unsure if they approve of the expanded role for nurses. More than this, they are disoriented by the phenomenal growth of participation by mass organizations in health work.

In addition, many people complain of long waits and the poor attention when they go to a clinic. Some groups feel that the Ministry of Health has not yet fulfilled its promise to provide adequate care, and pressure is being exerted on leaders to become better organized and more effective.

In the area of mass participation in health care, neighborhood groups such as the Committes for Sandinista Defense (CDS) help to build clinics, raise money and help in immunization campaigns. CDS representatives also run clinic and regional health care management committees. Each local CDS has one volunteer for monitoring the health needs of the block and helping the area clinic to carry out its work in that area.

Women's organizations, the Sandinista Youth group, farmers' organizations, the police and the militia are all taking part in designing and implementing health programs. These include treatment for infants with diarrhea, general nutrition, immunizations, malaria control, institutionalization of births and occupational health. The first steps in a program to popularize breast feeding have included treating artifical feeding formulas as controlled drugs. In addition, formula companies are no longer allowed to advertise freely.

Despite these gains, Nicaragua has a long way to go before it can be assured of a healthy population. Nevertheless, the Nicaraguan experience in incorporating international assistance, learning from the advantages and limitations of other health systems, using paramedics and community people, and resolving political tensions with the doctors can provide an excellent example to other developing countries. ■

How Do You Address A General?

Mr. President, Your Majesty, the Right Honourable—for most heads of state, the appropriate form of address is clear. But for a general? The problem arose after three Chilean physicians, Drs. Pedro Castillo, Manuel Almeyda, and Patricio Arroyo were abducted by the Chilean secret police last May. Their only crime was an association with a church group providing support to persons whose human rights have been violated.

Evan Collins, writing for the MRG, sent a letter of protest to General Augusto Pinochet, the Chilean president. Copies were sent to the Chilean Minister of the Interior and the Ambassador to Canada, as well as to Mark MacGuigan, Canadian Minister of External Affairs.

Due to pressure from a large number of groups in many countries, the three physicians were released in mid-July. Although they know that they will continue to be harassed, they have courageously chosen to persevere in their work in Chile.

The letter to General Pinochet was, by the way, addressed to "His Excellency".

Medical Aid to Nicaragua (MATN)

Medical Aid to Nicaragua (MATN) is a small voluntary organization formed less than two years ago to meet basic health needs in Nicaragua. MATN collects funds to obtain supplies, to support programmes, and to send health professionals as volunteers to Nicaragua. MATN is currently raising funds for the Volunteer Health Brigades, co-ordinated by the Nicaraguan Women's Association (AMNLAE). The brigades will be teaching and promoting nutrition, sanitation, public hygiene and community health care in Nicaragua. Contributions should be sent to 175 Carlton St., Toronto, M5A 2K3 and are tax deductible.

MATN is co-operating with CUSO in recruiting two health professionals, a *gynecologist* and a *nutritionist/dietician,* to work in Nicaragua for two years. Responsible to the Ministry of Health, the team will work at the 140-bed hospital and in the community of La Trinidad, Near Estelí, on the following aspects: in- and out-patient consultation, education and mother/child care. More detailed job descriptions are available from MATN.

Members of MRG are asked to consider this request, and share it with colleagues who may be interested in volunteering. Contact MATN c/o Dave O'Connor, OXFAM-Ontario, 175 Carlton Street, Toronto, Ontario, M5A 2K3, telephone: (416) 961-3935.

Community Health Centres: An MRG Perspective

by the Community Clinics Work Group

In May of 1980 the Community Clinics work group of the MRG presented a paper entitled *"A Study of Community Clinics: Evidence, Conclusions and Recommendations"* to the general membership. The paper was based on a review of the relevant literature and on the experiences of MRG members who have worked in various types of community health centres. The following is a shorter version of the paper, incorporating changes suggested by the membership at the May 1980 meeting. For those interested in the original paper, which includes an extensive bibliography useful to anyone wishing to do further reading in the area, copies can be obtained from the Hamilton steering committee, P.O. Box 1019, Main Post Office, Hamilton.

Definition of a Community Health Centre

In the following discussion, our model of a community health centre (CHC) is as follows: a group of health care workers with a broad range of special skills, operating out of a single physical facility, and assigned the tasks of health maintenance, patient education, the practice of preventive medicine, and the diagnosis and management of illness. The power to decide on the disposition of funds would be shared equally between clinic users and staff.

Present Problems and Potential Solutions— The Role of Community Health Centres

1) Preventive Medicine and Patient Education:

It has been suggested that in coming years the care devoted to guiding patients in health habits and in modifying life styles is likely to have a greater effect on health outcomes than all other health services combined. Much of the morbidity we see can be traced to behaviour directly under the individual's control: alcohol and cigarette consumption, diet, exercise. Other major causes of disease include factors which physicians, as citizens concerned about the health of their fellows, can potentially influence: occupational and environmental health hazards, social forces such as advertising which adversely influence individual behaviour, and social and economic environments which promote disease. Studies have demonstrated the utility of primary, secondary and tertiary preventive and educational programs in decreasing morbidity.

The importance of preventive medicine and patient education is clear. Nevertheless, the structure of Ontario's health care system reflects a virtually exclusive concern with the diagnosis and treatment of acute illness. The present fee schedule of the Ontario Health Insurance Plan does not even include a category for patient education. To the extent that doctors respond to economic incentives, the fee for service system encourages them to see as many patients as possible in the shortest period of time.

In a CHC, prevention would be a crucial aspect of the ongoing care of individual patients and would play a role in virtually every interaction between patient and health care worker. Payment of workers on a unit time rather than fee for service basis would eliminate the financial incentive for a high volume practice. Organized programs for people with shared problems or concerns would be an integral part of the clinic's service to the community. This approach would both prevent the development of disease and help patients to cope successfully with physical and social problems.

2) Inpatient versus Outpatient:

Being admitted to a hospital is an unpleasant experience for most patients. Hospital care is expensive (hospitals consume over 50% of the total health care budget), and the risk of nosocomial infection is significant. Clearly, it would be desirable to shift as much of ongoing medical care as possible to the outpatient arena.

To do so, however, will require both a change in attitude on the part of the medical community, and a commitment to reallocation of funds by the provincial government. Increased availability of rehabilitative services such as physiotherapy and occupational therapy, as well as expanded funding for supervision of the patient at home, are imperative.

Community health centres as we have defined them are ideally structured for the delegation and coordination of total medical services. Because clinic personnel would be working as a team, a health worker

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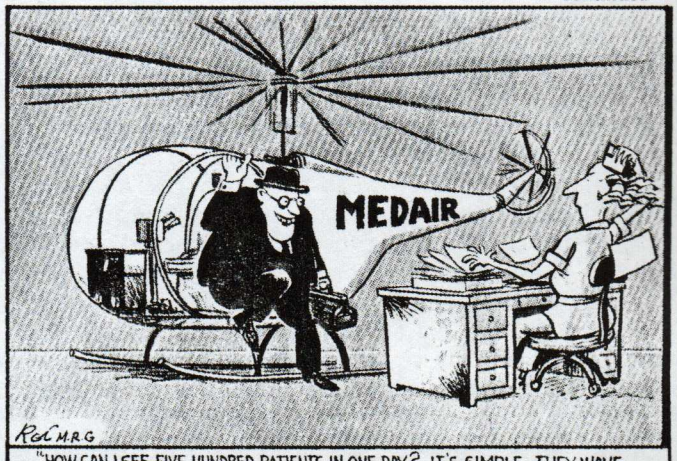

"HOW CAN I SEE FIVE HUNDRED PATIENTS IN ONE DAY? IT'S SIMPLE. THEY WAVE TO ME FROM THE GROUND!"

(whether nurse, physiotherapist, occupational therapist, etc.) visiting the home would have an in depth understanding of the patient's past problems and present status. Similarly, physicians would be apprised of how the patient was doing in the home environment and therefore have a clearer idea of how to make best use of available resources. Health centres which have utilized preventive approaches and co-ordinated services have been successful in reducing hospital admissions.

3) Control of Health Care Delivery:

At the present time individuals in this society have little control over a process which, when they are ill, has a considerable impact on their lives. It would be desirable for the public to have an opportunity to influence the nature and quality of health care at the local level. Local control would both engender a sense of responsibility in the individuals involved and provide direct feedback to the clinic staff, guaranteeing a responsiveness to local needs. In addition, community representation can fulfil some aspects of public responsibility which otherwise would be handled by a larger and more rigid provincial bureaucracy.

The public, then, must be directly involved in decision making in the centre. How is power to be divided between the health centre's executive council and the provincial government? We believe that the crucial decisions, those regarding the disposition of funds, should be in the hands of the clinic. Without this power, the centre will be impotent to deal with many of the problems it will inevitably face. Community health centres have, in the past, had their character, patient population, and service modalities altered or restricted because of strings attached to money they received.

If the government is to have a role in monitoring the function of health centres, it should be by reviewing outcomes. Criteria for evaluating appropriate function of the centre would be negotiated between the centre's representatives and the province. Under such a system the quality of patient care will be guaranteed while at the same time decision making will be shared by the staff and the public they serve.

4) Hierarchy Among Health Care Workers:

At present, decisions concerning patient care rest, by and large, in the hands of the physician. This is true both in hospitals and private practice. In solo and group practice, decisions concerning resource allocation are the exclusive prerogative of the physician. A whole assortment of trivial hierarchies result from the essential one which is established by the physician's monopoly on decisions concerning patient care and on how money is spent.

We see the centre as a setting in which the presently existing hierarchies could be broken down. First, clinic personnel would work as a team. This implies that decisions would be made by a consensus of the team members. Secondly, each clinic worker would have an equal opportunity to serve on the executive council and participate in decisions concerning policy directions and resource allocation. The community health centre would thus lead to a significant change in the roles existing in most current health care settings; that is, the physician as boss and other workers as employees.

An additional element which tends to maintain the present hierarchy is the large differential in income that exists between different health care workers. It would be desirable to see these income differentials reduced in the health care setting. In practical terms, the issue is problematic. Paying doctors below the going rate leads to problems recruiting high quality individuals. Clinics in Ontario have as a rule relied on doctors who are highly motivated politically and willing to accept less than they would receive in the open market. As the number of health centres increases, this method of income equalization depends on a growing supply of suitably altruistic physicians. A truly satisfactory solution must wait upon society's recognition of the equally valuable contribution of all health care workers.

5) Education of Health Care Workers:

The majority of physicians and allied health workers in Ontario today do not have easy access to day-to-day educational activities. The opportunities for learning through informal contact with colleagues may be negligible.

A program of formal education for the staff would be an integral part of the community health centre's activities. Through interaction with other members of the health care team, each individual would have informal learning opportunities which are rarely available within the present structure of health care delivery. The co-operative and educational atmosphere engendered by regular mutual consultation and discussion is one of the most positive features cited by those who have worked in community health centres.

6) Saving Money:

Whatever minimal support the provincial government has given to community health centres has been based on the expectation that they might save over the short term. These expectations have arisen largely as a result of the experience with prepaid group practice in the United States. Prepaid plans such as Kaiser-Permanente cost less than traditional methods of delivering health care.

To extrapolate the expectations from American prepaid plans to Ontario community health centres without modification is foolish. The American plans which have demonstrated savings are well established, huge institutions, many with well over 100,000 patients enrolled. The basis of their decreased cost include economies of scale, access to multiple specialties in a single building, and access to day beds. The latter two factors are instrumental in reducing hospitalizations. In addition, they have the benefit of enrolment prior to the client seeking medical care which means a significant proportion of their members pay up without utilizing services. Clearly none of these advantages apply to small Ontario clinics which must recruit patients at the point of their seeeking medical attention.

Despite these disadvantages, the limited studies of Canadian centres suggest that they cost no more, and perhaps less, than conventional health care delivery systems. The studies available are plagued by methodological problems. Most of these result in a bias against the health centres. Health centres tend to be established in low income areas with a large number of elderly patients leading to increased utilization and hospitalization. Finding a suitable control population is extremely difficult. Expenses of extra billing charged by

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control physicians but not by the CHC's are almost impossible to quantitate.

The goals of CHC's include optimizing patient care, and increasing use of medical and social services by groups which traditionally underutilize them. For health centres to accept the expectation that they will improve care, alter patterns of underutilization, and at the same time save money, may be stacking the cards against themselves in any future evaluation of their performance.

At the very least, any evaluation that does take place should consider the methodological problems, most importantly that of providing suitable controls. In addition, studies evaluating CHC's versus traditional health care delivery should examine indices of the quality of care delivered as well as cost. To neglect these considerations in their negotiations with the government may ultimately be fatal for Ontario health centres.

The Logistics of Establishing a Community Health Centre

We have adduced evidence which suggests that CHC's could play a role in the amelioration and solution of the problems confronting the present health care delivery system. It is important as well to look at some of the most important practical problems which health centres will face. Once again, we have drawn on our literature review and on the experiences of MRG members who have worked at health centres in arriving at the following observations.

1) What is the "Community" in Community Health Centre?

The ideal environment for the establishment of a clinic would be in a well defined, pre-existing community which had itself expressed the need for a health centre. Such environments are unusual. In the absence of such a situation the health centre must establish clear goals and priorities and a clear definition of the population they are serving. Only then can resource allocation be reasonably resolved.

There is an uncomfortable irony in the notion of the health centre defining the community. In this context it is an important goal for the MRG to educate the public on the potential benefits of community health centres. Efforts in this direction have contributed to the growth of a citizen's group in the east end of Hamilton which is at present demanding a health centre based on the MRG model.

2) Financing:

Community Health Centres have had to learn the rather bitter lesson that although sincerity, dedication, and political commitment may be enough to work with temporarily, in the absence of adequate funding insurmountable problems arise quickly. In Ontario today most centres are financed under the government's capitation-negation scheme. For most clinics which operate in low income areas with a population in which there is a high morbidity, a high prevalence of individuals not covered by provincial health insurance, and a reluctance to sign on with any one physician or group of physicians, this method of financing is highly unsatisfactory. A few CHC's negotiate with the government for a global budget, and these have had variable success. For those contemplating establishing a health centre at present, the options are to work from O.H.I.P. billings, try and supplement O.H.I.P. income with additional grants for specific projects (a dubious option), or enrol in the capitation-negation scheme. The latter is a viable possibility only for those with established practices.

Obviously, none of the present funding options are entirely satisfactory. A significant shift in government policy is the prerequisite for the financial security, and perhaps economic feasibility, of present and future health centres.

3) The Community Health Centre Executive Council: Balance of Power:

The reasons for public involvement in clinic decision-making have been outlined previously. There are, however, major problems associated with such involvement. Without a constituency, community representatives may just represent their own or their friends' interests. Their understanding of the language of health planning or the issues involved may be limited. There is a cost to participating in terms of time and energy, a cost which may well be too great for many people.

Measures may be taken to deal with some of these difficulties. The health centre must actively encourage the participation of as large a number of citizens as possible, thus minimizing the chance that narrow or selfish interests will be represented. Efforts must be made to keep the executive council in the mainstream of incoming information. Educational programs may be useful in increasing the knowledge and effectiveness of community members, but increase the time and energy

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required of them. We do not expect these suggestions will solve all the problems referred to, and as experience accumulates we must be alert to the possibility of new approaches that may help to remedy them.

A second set of problems arise from the interaction between staff and community representatives. Inevitably, the interests of these two groups will differ to some extent. These differences can cause a great deal of difficulty, and have led, on more than one occasion, to a complete rupture between the board and the doctors, and the effective destruction of a clinic.

The crucial decision in regard to the problem of staff-consumer disagreement is that of the composition of the executive council. By executive council, we mean the group which makes the final decisions concerning the clinic's policies and disposition of funds. We feel that the community and the clinic workers, including the physicians, should receive equal representation. This is likely to be the most effective means of preventing abuses of power by either group.

Despite the problems, there have been many clinics in which extensive and direct community participation in decision-making has worked out very well. Thus, there is good reason to believe that the administrative bodies, as we envisage them, would insure responsiveness to the community's needs while protecting the interests of the centre's workers.

Conclusion

There are many problems with the structure of the health care system in Ontario. It is geared toward diagnosis and treatment of acute illness; little more than lip service is paid to prevention. Decisions concerning resource allocation are made on the basis of political considerations which often bear little relevance to the needs of those affected, and are implemented by a large and insular bureaucracy.

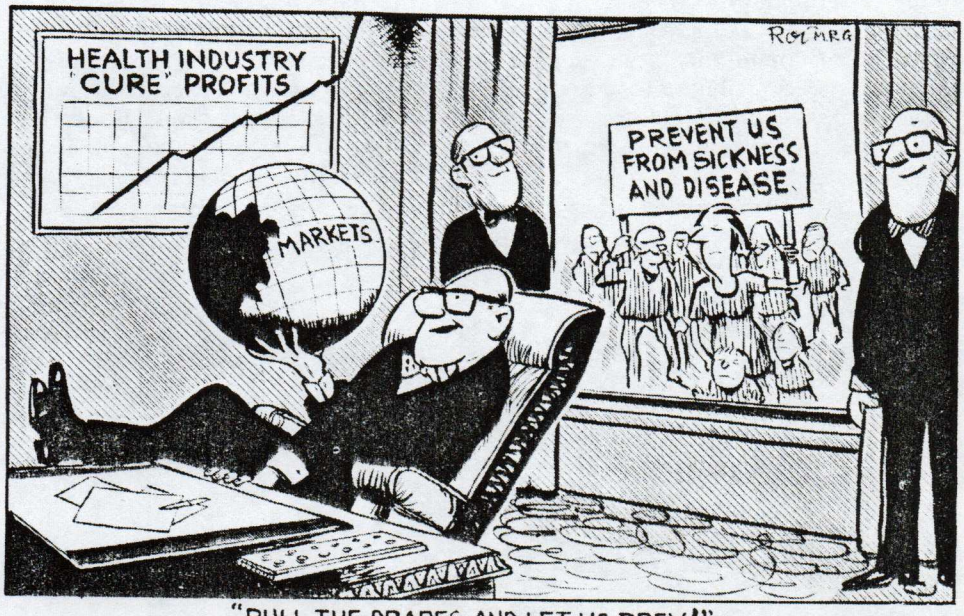
Community health centres of varying design have been experimenting with alternative approaches to health care in Canada and the United States during the last twenty years. Ontario has a number of active centres, several staffed by MRG members. American and Canadian CHC's have tried to shift the focus from treatment of acute disease to prevention, patient education, and health maintenance. Were such principles applied on a large scale it would likely, over the long term, result in a significant improvement in the health status of the population.

There are other important features of what we see as the ideal community health centre. Increased availability and improved co-ordination of out-patient services can decrease hospital admissions. As a result, care dispensed by health centres may be less expensive than conventional methods. Although the studies are limited and methodological problems abound, the available data suggest that community health centres do decrease hospital admissions and lower costs.

The final crucial characteristic of the health centres we envision is community involvement. This must be in the form of a true devolution of power from the provincial government so that the centres' executive councils, made up of local citizens and clinic workers, decide how resources are allocated and money is spent.

The major factor limiting the growth of community health centres is inadequate funding. While we would encourage like-minded physicians, especially those involved in primary care, to try and model their practices upon the principles we have outlined, major growth in community health centres must await changes in goverment policy. Worthwhile goals for the MRG might include educating the public about the potential of community health centres, allying ourselves with other groups who support their development, and together lobbying the government for increased support for health centres which incorporate the features which we feel are crucial to their success. ■

MRG members whose research and discussion contributed significantly to the preceding article include Nick Kates, Bob James, Fran Scott, Gord Guyatt, Don Woodside, Karen Jones, Ken Burgess, Bill Courtade and Joel Lexchin.



"PULL THE DRAPES AND LET US PREY!"

The Toronto Health Advocacy Unit and the New Public Health Movement

by Trevor Hancock

In 1978, the Local Board of Health of the City of Toronto published the landmark report **Public Health in the 1980's,** which charts a new course based upon several recognitions - that the major threats to health are now man-made and hence social and political in nature; that the Department needs a strengthened research and information capability, and an educational, promotional and political advocacy based on sound research; and finally that the Department should decentralize its activities and encourage community involvement in public health concerns.

The Health Advocacy Unit was created in 1979 to meet the needs for information, research and analysis in the Department, and to provide educational, promotional and advocacy skills. On the research side are a biostatistician, an epidemiologist, an investigative researcher and a health planner (myself). This team is mainly concerned with developing a health status report, helping to develop core programs, preparing a community health survey, developing an information system and planning evaluation. Members of this team, together with other members of the Unit have also been involved in research into such controversial health issues as high risk pregnancy, mammography, radiation exposures (e.g. video-display terminals), asbestos and chemicals in the environment.

The Health Advocacy Unit works on the premise that health has social, political, economic and ecological dimensions, and that the man-made threats to health that the City's residents face frequently have their origins beyond the bounds of the City. Such threats to health are often mistakenly viewed as being "lifestyle diseases" when they are in reality the result of a lifelong process of socialization within a specific social and political system which profoundly influences, and often consciously manipulates human behaviour. Thus effective action to deal with the major health problems of the next few decades requires a collective approach with extensive community involvement and a greatly increased focus on preventive and community based health services.

We believe that there are two fundamental principles which must underlie the new approach to public health, and which will unite a potentially disparate coalition into a new public health movement. These are the principles of ecological sanity and social justice. ***Ecological sanity*** implies that human health is dependent upon a healthy, stable and safe ecosystem. Activities which impair the health of the ecosystem (such as acid rain produced from burning coal, the extensive use of herbicides etc.) can be viewed as being ecologically insane, and ultimately a threat to mans' health.

Social justice implies that health is dependent upon a just and equitable distribution of wealth, and thus of health. This principle also recognizes that health care should be distributed on the basis of social justice rather than of market justice. The application of the principles of ecological sanity and social justice within the field of public health offers an exciting challenge to us all, and a worthwhile one since ultimately humankinds' health and well-being locally and globally can be vastly improved. ■

The Toronto Occupational Health Resource Committee (TOHRC)

by Brian Gibson

TOHRC is a group of workers, educators, legal and health professionals who have joined together to promote the right of everyone to a safe workplace. TOHRC has functioned under this name for a year and a half, but the group has been active for over five years. The aims of this group, as stated in its constitution, are to promote the right to a safe workplace by:

1) helping to educate individuals and groups on health and safety matters, both inside and outside the labour movement, including unorganized labour;
2) acting as a resource and support committee to workers, encouraging the development of skills and knowledge in health and safety matters;
3) encouraging and supporting political action on health and safety and workers' compensation issues;
4) encouraging the development of a network of individuals and groups relating to health and safety issues;
5) initiating and promoting public discussion on occupational health and safety issues.

TOHRC has opened a part-time resource centre for workers in Toronto. It is located at 717 Pape Avenue, suite 300, at the Pape subway station. The space is shared with Injured Workers' Consultants. The centre is open on the second and fourth Saturdays of the month from 1000 to 1400 and can be reached by telephone 416-461-0576.

I prepared a brief entitled "The Social Challenge of Asbestos" which was submitted to the Royal Commission on Matters of Health and Safety Arising from the Use of Asbestos in Ontario. This brief has been endorsed by the Steering Committee of the MRG. The brief was presented to the Royal Commission

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in the first phase of hearings on February 18, 1981. TOHRC has legal standing for the second phase of the hearings—the formal calling of witnesses—that will take place this summer. This means that TOHRC will be able to call its own witnesses and cross-examine the witnesses of others.

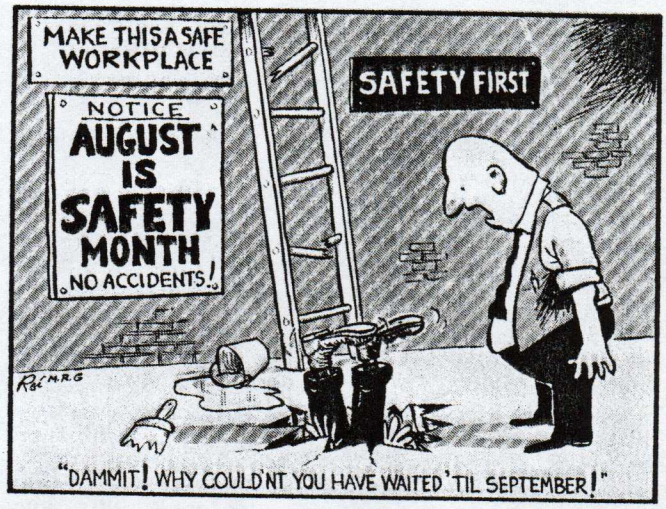
The recommendations which TOHRC made in its brief include the following:

-that an integrated program to ban asbestos in Ontario be adopted;

-that adequate research to define substitutes for asbestos be undertaken; the immediate costs of asbestos control be assessed to the corporate sector that has benefitted from the use of asbestos;

-that the hazard of asbestos not be exported to other nations, especially third world countries, for economic profit. With the development of viable alternatives for asbestos use, all production of asbestos in Canada should be stopped.

A copy of the full brief can be obtained by writing to me through the MRG. ■



MRG ISSUES

WHY THE MRG?

by Gord Guyatt

Since the inception of the group it has been clear both to our members and to those we have been fighting for, and against, what the MRG stands for. The central principles of equal access, recognition of the social and economic roots of ill health, and a greater role for the public and for non-physician health care workers in health policy decisions are as familiar to many members as is the national anthem. There has, on the other hand, been a great deal of confusion as to our essential goals.

It is time to define our goals as clearly and explicitly as we have defined our principles. The following is a suggestion, a draft, for such a document.

The goals of the MRG are as follows:

1) To provide a voice for progressive, socially-conscious physicians in Ontario. Through public statements and activities to let the citizens and government of Ontario know that the traditionally conservative medical organizations do not speak for all physicians in the province.
2) To lobby the provinical government and associated health agencies so as to influence, in accord with our underlying principles, decisions which effect the health status of Ontario citizens.
3) To ally ourselves in a relationship of mutual support with other individuals and groups working for positive change in the health care system.
4) To analyze the principles and structures on which the present health care delivery system is based. To raise for discussion and support innovative ideas, the institution of which would improve the health status of the people of Ontario.
5) To educate ourselves, other health care workers, and the public with regard to the present determinants of health and how they could be productively changed.
6) To provide a public service to individuals and groups for whom our special knowledge, skills, and attitudes may be of benefit.
7) To provide a mutual information and support group for health care workers who share our basic principles. To endorse and support the work of individuals and groups of health workers engaged in activities consonant with these principles.

I would encourage anyone with ideas about possible additions or deletions to get in touch with me, (47 Forestview Drive, Dundas, L9H 6M7, 416-628-0162). A definition of goals will be on the agenda of the next general meeting, and it would be desirable to have as much basic discussion around the document as possible before the meeting. ■

Medical Reform Group General Meeting Toronto. Oct. 17 & 18, 1981

GREG STODDART

Health Economist, McMaster University, will be joining us Saturday afternoon for a discussion of issues related to the funding of health care in Ontario. The setting will be informal, allowing for maximal interchange between Dr. Stoddart and those in attendance. A number of important controversial questions will be addressed.

These include:

- the pros and cons of health premiums
- a possible role for competition in the provincial health care scheme
- the effects of user fees
- alternative methods of physician reimbursement

Dr. Stoddart is a co-author of "Controlling Health Costs by Direct Charges to Patients: Snare or Delusion?" a report familiar to MRG members who have participated in the economics work group. Given the MRG's present focus on health care funding, the discussion should be both timely and informative. Dr. Stoddart will be happy to address additional issues of particular interest to those attending.

TENTATIVE AGENDA

Saturday A.M.

Reports:
- working groups
- steering committee
- financial report

Saturday P.M.

Health Care funding
- Dr. Greg Stoddart

Saturday P.P.M.

Supper and Party!
Plan to attend.

Sunday A.M. and P.M.

Down to business:
- Administrative Assistant: Who, Where, When, How, and a job description
- Budget
- MRG goals
- Role of the Steering Committee

A subsequent mailing will include a final agenda and a location. It promises to be an exciting meeting—with its share of fun.

OCTOBER MEETING— DECISIONS TO BE MADE

A major turning point for the MRG appears to be imminent: the hiring of a part or full time administrative assistant. So much was agreed at our last meeting in May. The role of the administrative assistant, an appropriate source of funds, and changes in the structure of the MRG to accomodate the new situation are all issues which must be decided on. A group of MRG members met in London on July 26, 1981 to discuss these questions and review the May meeting. The following represents some of the queries raised at the London gathering.

Role of the Administrative Assistant

Ideally, we would hire a full time person with a university education and secretarial skills who could take over much of the administrative duties now performed by the steering committee. These include membership records, mailings, organizing meetings, collecting fees, and co-ordinating group communication. In addition, a full time worker would be able to do research in target areas such as health care funding.

This vision is indeed an ideal, and, if one takes into account salary, office space, a telephone and expenses for other paraphernalia, the cost might be close to $25,000 yearly. In the absence of this sort of riches a part-time secretary may be a reasonable alternative. Another option would be borrowing a secretary working for a union or other allied organization on a limited time basis. Such a compromise would be suitable in the absence of sufficient hard cash for a separate hiring.

How to Get the Money

An exploration of possible source of funds is underway. One of the more illustrious MRG members, Monique Begin, has been approached for suggestions. Other options include the labour movement, various government funding programs, or even the United Way! How would MRG members feel about the level of association implied by accepting money from any of these groups?

The alternative is to raise the money within the group. Two hundred MRG members paying $100 each

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on a yearly basis would give us $20,000 of disposable funds. The probability of such generosity on the part of our membership has, to date, been met with considerable skepticism.

The Decision-Making Process

Another major issue related to hiring a full time worker is the future role of the provincial steering committee. According to the constitution, the steering committee has an essentially administrative and organizational role; direction for policy-making must come from the general membership.

How has this process worked so far? Several of those for whom the May meeting was the first exposure to a general membership free-for-all found much of the discussion disorganized, divisive and unproductive. Veteran MRG members (fingering gray hairs generated by a host of previous plenary sessions) felt that the meeting represented an improvement on past efforts. Nevertheless, it was a concern to all that new MRG members could be alienated and unimpressed by the conduct of the meetings.

A number of specific questions arise from these musings:

1) Is consensus decision-making and grass roots democracy realistic and productive given the size of the membership and of the general meetings?
2) What is the point of the large group discussions? It may be that a focus on discussion of substantiative issues, rather than a focus on wording, would make for a more satisfying interaction. If so, should resolutions be passed in spirit with the steering committee (or some sub-committee) delegated the responsibility of dealing with the semantics?

   Are the large group sessions an appropriate forum for discussion at all? Perhaps issues should be hammered out in local groups, synthesized by small groups at the biannual meetings, and merely voted on in the plenary sessions.
3) Should the steering committee take a more active leadership role? This could take several forms. Policy could be presented to the group at general meetings for approval. For example, in October we could be presented with specific proposals as to whom we should hire, what the person would do, and where the money would come from. This would contrast with the approach that has been taken up to now on many issues which could be characterized as "Here's the problem. Now what do you think we should do?" It could be argued that the latter modus operandi has led to many hours of frustration and unproductive discussion.

Summary

Clearly, I have done no more than raise the issues and ask what I hope will be seen as pertinent questions. Answers will have to be provided in October. We must arrive at a job description for the administrative assistant, must decide on what is an acceptable and feasible method of funding. In addition, for the administrative assistant to function optimally in a relationship with the steering committee, the role of the committee must be clarified. I present these questions in the hope that they will be considered by individuals and discussed in local groups prior to October. If so, the result may be discussion and decisions that foster a sense of unity and common purpose at the general meeting. ■

Contributed by:
Marielle Skinnarland, following discussion with Bernie Hammond, Barbara Lent Sheila Zubrigg, Philip Hebert, Dan Way, Gord Guyatt and Fran Scott

WITH A LITTLE HELP FROM OUR FRIENDS

Editorial and production work for this issue of the MRG Magazine was done by Gord Guyatt, Marielle Skinnarland, Fran Scott, Benjamin Loevinsohn, Don Woodside, Pat Smith and John Marshall. Thanks to Gene Vayda for an extremely useful review of "Community Health Centres—An MRG Perspective." Special thanks to Roy Carless, professional political cartoonist, for the superb, incisive cartoons.

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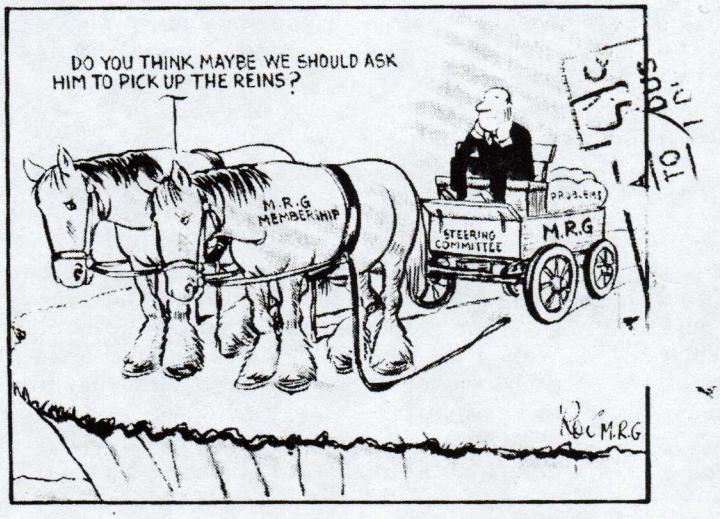

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