

# MRG Newsletter

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

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"MEDICINE IS POLITICS WRIT LARGE" -Rudolf Virchow

## Fall General Meeting

The Medical Reform Group's fall general meeting has been scheduled for Friday October 21 and Saturday October 22.

The meeting will differ somewhat from the usual format in that less time than usual is being devoted to business items, and more time to plenary and discussion. The planning committee has attempted to develop an agenda that will focus discussion on **"where does the MRG go from here?"** This focus grows out of the idea that the MRG is at a turning point, and that the group needs to decide on its priorities for the next couple of years.

The Friday night session will be at Trinity College at the University of Toronto. The meeting starts at 8 p.m., but the small dining room at the college is being reserved for a dinner at 6 p.m. The cost for the meal will be \$10 per person. **People planning to attend the dinner are asked to RSVP by October 12**, because we need to let the college know how many people will be eating. Please call 588-9167 and leave a message if you will be coming for the dinner.

The Friday night session at 8 p.m. will feature a panel with three speakers, followed by a plenary discussion. The first speaker will be Gord Guyatt, who will give a **brief history of the MRG**. John Frank will speak on **prevention and its role in the health care system, especially as it relates to primary care**. Bob James will talk about **models of primary care delivery**. A discussion will follow.

The Saturday session is at the South Riverdale Community Health Centre, 126 Pape Ave., Toronto. Registration is from 8:45 to 9:04. The meeting will start at 9:05 sharp.

From 9:05 to 10:15 there will be a steering committee report, the presentation of the annual budget, and discussion of constitutional amendments.

From 10:30 to 12:30 there will be **workshops**. Topics are **scope of practice, including general practice issues; professional identity issues; and doctor/patient contract issues**. Some of the questions proposed for discussion at these workshops are: Is the model of physician and ancillary

workers 'the' way to provide primary care? Do Community Health Centres represent the most progressive path to a rational provision of services or are they destined to always be a solution only for the marginalised? What is our role as individual practitioners in the overall socio-economic milieu? Stopping people from smoking would have a greater impact on the general health of Ontarians than all of us together -- what are the implications of this? What professional duties/responsibilities do we have in the face of personal needs (e.g. obstetrics)? How do physicians in practice in the community keep in touch with each other?

Lunch will be from 12:30 to 2:00.

From 2:00 to 4:00 there will be a **plenary which will attempt to pull together the themes of the weekend**.

The registration fee for the weekend will be \$25. However, people who pre-register by mailing in their fee in advance will be able to do so at the reduced rate of \$20.

Watch for more details in the next newsletter.

## Notice to membership regarding constitutional amendment

At the Spring General Meeting a proposal was made to change the constitution of the MRG to help us carry on our business.

Specifically, the resolution as discussed stated that: "Whereas the business of the MRG has on at least one occasion been held up by the lack of an official quorum, and, whereas as the organization grows this will become an even more frequent occurrence, Therefore be it resolved that the constitution of October 1979, amended October 1987, be amended so that section 30 read: "A quorum at such a meeting be 10% of the paid up full membership at the date of the meeting" and section 42 be amended to read "If after presentation at a general membership meeting a quorum is not achieved, a mail-in vote

may be taken. Ballots must be received from 30% of the total voting membership, and a two-thirds majority of the mailed-in vote is required to pass a constitutional amendment. The votes must be received within a time specified at the time of notification of motion."

The first part passed by 23-0, the second by 22-0, with two abstentions. Unfortunately neither was a large enough number to allow for it to be an amendment under our current constitution. Therefore the Steering Committee has decided that they will provide this notice through the newsletter:

We would ask that, if any member has objections to the amendment being passed, that they let us know by

mail before the October General Meeting, or come in person to voice their objection.

If there are objections, the issue will be discussed during the meeting.

If not, it will be considered passed.

We understand that this procedure is not strictly according to the present constitution, however we can see no other way out of the current dilemma.

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# Report on the IV International Conference on AIDS

June 20, 1988

The IV International Conference on AIDS was held June 12 - 16, 1988 in Stockholm, Sweden. There were over 6,800 participants including scientists, health care providers and policy makers. Over 3100 abstracts were published in 1000 pages of the 2 volume conference book. The abstract subject areas were: virology, pathogenesis/immunology, antiviral therapy, epidemiology, developing world, prevention, clinical management, psychosocial aspects and healthcare and society. The morning plenary sessions reviewed the current state of knowledge in all subject areas. Conference participants interested in particular areas were provided opportunities to receive more detailed presentations through nine concurrent workshops or round tables occurring twice each day. In addition there were hundreds of poster presentations in each area for participants to review. Because of the massive number of presentations, the conference executive did not expect participants to attend/review more than 10 percent of the presentations. Thus one had to carefully select the sessions/posters relevant to their area of interest.

The virology and pathogenesis/immunology sessions informed participants of the complex regulatory loops governing the activity of the human immune deficiency virus (HIV), the manner in which the virus causes disease at a cellular level and the major obstacles delaying the development of an effective vaccine. The information presented was useful for clinicians in conceptualizing the pathophysiology of HIV disease and providing a scientific knowledge base with which to counsel patients, particularly those who are hoping for a vaccine in the near future. Similarly the scientific progress on anti-viral therapy (which was not very hopeful) served physicians well who must ad-

verse patients on the realities of effective treatments for HIV disease. Although many papers were presented on laboratory research and clinical trials on numerous drugs, there were no major announcements on treatment. The use of AZT (Zidovudine) alone or in combination with immunomodulators and other anti-virals still holds the most immediate hope for patients currently infected with HIV.

The epidemiology and prevention sessions provided up to date data on the pattern of spread of HIV, the risk factors for acquiring HIV and for developing AIDS once infected, and strategies for preventing HIV acquisition in individuals practicing high risk behaviours. This data is much more applicable in day to day clinical practice than much of the basic science information. For example it has been established that alcohol and drug abuse are risk factors for HIV acquisition in the gay population. Risk factors for heterosexual acquisition of HIV include genital ulcer disease, cervical chlamydia, the use of oral contraceptives (? due to cervical ectopy) receptive anal intercourse, frequent douching, the use of tampons, a history of vaginitis (non-monilial) and a history of cervical gonorrhea. Data on syringe/needle exchange programs from six large urban centres revealed that the spread of HIV stabilized or decreased with these programs and drug use did not increase. Conference leaders stated that what was once unimaginable is now necessary for control of HIV in the drug using population and to prevent spread from the drug users into the heterosexual population. As a senior justice from Australia stated in a closing plenary address, "it is time that drug use was taken out of the courts and jails and put into the area of public health where it belongs". Needle ex-

change programs will be part of any effective public health strategy.

The clinical management presentations further described numerous disorders that accompany HIV disease and provided data on current treatments of infections/tumors occurring secondary to HIV. In addition, studies on the clinical and laboratory features that are prognostic indicators in HIV disease were extremely beneficial for clinicians caring for HIV infected patients.

Finally there was a strong emphasis on the psychosocial aspects of HIV disease. Indeed throughout the scientific conference there was another "conference within a conference" entitled "The Face of Aids" which dealt with the humanitarian side of AIDS. The humanitarian theme was present throughout the main conference as leaders in research acknowledged the importance of "justice" and "solidarity" in the treatment of AIDS victims. To quote the Swedish Prime Minister who opened the conference: "the battle against AIDS can be won in the laboratories and lost in the streets". Issues discussed under the broad topic of psychosocial and humanitarian aspects included: anonymous testing, anti-discrimination laws, equal access to health care services, the relationship between poverty and HIV disease and the duty of developing countries to assist third world countries (the devastation of AIDS is so great in third world countries that it is predicted population growth will be reversed).

In summary, this conference was extremely useful for clinicians in day to day practice and for physicians in a leadership position (within the profession) who must recommend social and public policy to governments.

*Philip Berger*



# The National Health Service: Part I

*"What ransom will property pay for the security which it enjoys? What insurance will wealth find to its advantage to provide?"*

*Joseph Chamberlain, reformist wing Liberal Party, 1876-1903. (1)*

Myths about the NHS vary by political stripe. For many progressives the birth of the NHS in 1945 represented victory over reaction. For conservatives, the decline of the NHS today shows the failure of State Nationalisation. Both ignore that a social consensus had been developed by fear of rebellion, need for cannon fodder and a productive work force, and rank inefficiency. By 1945 both Tory and Labour heeded Alexander Pope:

*"For forms of government let fools contest; Whate'er is best administer'd is best." (2)*

Not only was there a consensus between the 3 parties on health, but also on steel, coal, railways etc. Virchow's dictum quoted on our headline truly applies to the formation of the NHS.

If this is so, health reformation may not be a simple untrammelled "progress". Why do ruling governments concern themselves with health issues and when do they do so? What strategies should progressives then adopt in fostering change? Should progressives view doctors as thoroughly reactionary or as capable of taking a progressive stance? The NHS is a paradigm for answering some of these questions, because its history covers an economic era of Britain from a rising power to a falling one. Its lessons apply today.

## 19th Century:

Even the early steps in preventive health were precipitated by fear of labouring militants. Thus the great proponent of Sewer Reforms, Edwin Chadwick, recognised the link between ill health and militancy. His Report of the Sanitary Conditions of the Labouring Population of Great Britain warns:

*"Chartist meetings held by torchlight in ... Manchester ... consisted of mere boys ... older men, we were assured by their employers, were intelligent and perceived that capital*

*was not the means of their depression, but of their steady and abundant support. ... The disappearance by premature deaths of the heads of families and the older workmen ... must ... involve ... the lapse of staid influence amidst a young population" (3). Naturally other forces also impelled reform, as adduced by Chadwick -- cost saving of the Poor Law "pecuniary burdens" (4); increasing productivity of the sick work force (5); and need to contain contagion (6). The Poor Law, operated by local government was the only recourse to relief for the unemployed and poorly paid. It operated on the negative principle that the able bodied must be: "Subject to such recourse of labour and discipline as will repel the indolent and vicious". (7) (Modern Social welfare rules in many countries seem no different). The regime of the Poor Law (known to the working man as Bastilles) was correspondingly harsh. Most physicians were usually paid employees of the Poor Law Unions. Against them they had many battles, not just for their own salary, but to alleviate the conditions of the inmates.*

## Lloyd George:

In the 1906 Ministry of Lloyd George a central problem was to: "try and accommodate the rising power of organised labour." (8) New Unionism had sent its Labour representatives to Parliament, in the election of 1906. (9)

In addition the Boer War (1899-1902) showed that over 50% of the potential recruits were too ill to be drafted, leading to the School Medical Service. Just as in the 'Great War' of 1914:

*"The population inevitably came to be seen as a biological resource without which the war effort could not function ..." (10)*

The events in Soviet Russia further exacerbated tensions, by creating a precedent for organised labour. Even before the end of the First World War, Lloyd George was to say:

*"The working class will be expecting a really new world. They will never go*

*back to where they were prior to the war." (11)*

These considerations prompted reform - the Health Insurance Act (1911), the creation of the Ministry of Health (1919), and the transfer of the hated Poor Law Guardianship to the municipal governments (1929). Nonetheless only employed people were covered by the Insurance Act; not even their dependents.

## War The Midwife:

Just as the First World War had fueled change, so did the Second World War. War preparations were made some time prior to its outbreak. The Barcelona Ratio (from the air raids in the Spanish Civil War) had been calculated to gauge the new technology of air raids. It estimated effects on the civilian population, now at unprecedented vulnerability in time of war. Simply put, Britain could not face a likely air assault. (12) There was a chaotic patchwork of private (Voluntary) hospitals which were essentially charitable, and municipal hospitals provided under "permissive legislation" (therefore not obligatory) (13) which catered to the poorest of the population, and a tiny totally private fee paying clinic system. Deficiencies of the services included: urban concentration of facilities leaving sectors totally devoid of services (14), an overall shortage of beds by at least a third as calculated by the Nuffield Trust's summary of 10 official Hospital Surveys of 1945, (15) shortage of equipment (Titmuss points out that the anticipated war led to a demand for artery forceps equivalent to the previous 30 years) (16); shortage of specialist medical staff (17) an overall "disorganization" - with very small hospitals duplicating expensive services (18), and no coordination between the Voluntary and Public hospitals (19). To cap it all the Voluntary Hospitals were in very poor financial shape. Already the inadequacy of charity funding prompted government funding after the First World War. (20) However even this was not enough to keep them solvent. Eckstein concludes:



*"The inescapable conclusion is that Britain had no hospital "system" before the Appointed Day (of the NHS)." (21)*

All this led to a situation where physicians as well as patients were anxious for change. All these various forces drew to the consensus that reform was required. The Lord Dawson Report of 1920 (chaired by a Conservative) produced a far reaching call for reform, antedating that of the Socialist Medical Association. (22) The British Medical Association (BMA) had produced their own version of reform in 1938, as did the Medical Planning Commission (composed of the BMA and the Royal Colleges) in 1942. But perhaps the most influential report was that of Beveridge, the Liberal Party Chair of the World War II Coalition government of social insurance. The Beveridge report placed medical planning in the context of general social policy, arguing for a "proposal of comprehensive protection against the exigencies of life, cradle to grave". (23) The Tory Minister of Health, Mr. Henry Willink began negotiations with the profession and the local authorities.

It should be obvious that the gap between ideologues of "left" and "right" was not so very great. The 1938 BMA first Principle read: "the system of medical service should be directed to the achievement of positive health", and the 4th principle pleaded for a "planned national health policy". (24)

There appeared to be much common ground. What was all the brouha about then, when the NHS was "hijacked" to be Labour's "Jewel in the crown", as the election manifesto read of the NHS? Nowadays it is easy to forget what the world looked like at the end of the War. The Russian defense against and subsequent assault on Nazi Germany had inspired many sections of society. Even in the British Army such popular affairs as the Cairo Parliament - a mock Parliament - were symptomatic. The Cairo Parliament was broken up because of "subversion" after resolutions calling for nationalizations, including of banks, were passed overwhelmingly! (25) When the Coalition War Government broke up despite the all-Party agreement on the implementation of reform, an election was held and a caricature of socialist bashing began,

even though the policies of nationalisation were acknowledgedly supported by the majority of people in Britain. The Tories and Churchill claimed to recognise only Fascism in the Labour Party. Nothing was more calculated than this inflammatory slander to offset the enormous personal popularity of Winston Churchill (26). In 1940 George Orwell had said that: "We cannot win the war without introducing Socialism". (27) The aspirations of home coming soldiers, and war weary civilians were channelled into the Labour Party. The paint of a "socialist nationalisation" had to be applied to an already achieved social consensus.

In view of the "Battle" that seemed to be raging between ideologies, it is not surprising that the BMA themselves were fooled into believing that Socialism was dawning and that they would be made bureaucrats. Some vilified Bevan (Labour Minister for Health) as a 'Hitler'-strong words in 1945. The BMA now reneged on their previous commitment to reform. Progressives have interpreted this to mean that doctors are a hopelessly anti-progressive group. The facts do not support this interpretation, but suggest that even at the stage of confrontation with Bevan, most doctors stood for reform. It was certainly the case that the BMA behaved in a most un-democratic manner, disregarding their own constituents; as they have continued to do at various times since. The basis of my contention is contained in the Questionary of the members taken after the publication of the White Paper, which had a very good response. As Eckstein says: "On every substantive issue there was a clear majority for the scheme, and nearly 40% of the profession were for the White Paper, lock stock and barrel .... the results of the Questionary must be interpreted as a repudiation of the BMA leadership ... the profession approved a free service ... by a vote of 60 to 37% ... the profession approved a Central Medical Board to be established with powers to keep doctors out of relatively over-doctored areas ... by a vote of 57 to 39% ... The rank and file approved the idea of group practice in health centers by 68 to 24% ... the abolition of the sale of practices was approved by a large majority ..." (28) The bulk of the physicians however

balked at the concept of "State Salaried service" (29). Doubtless their memories of the Poor Law, the fear of the local authority (Eckstein: "Clearly the doctors did not fear nationalization as much as municipalization" (30). and the astonishing propaganda ladled out at this time, e.g.: "no Socialist system can be established without a political police ... some form of Gestapo ...", W. Churchill (31)). It is also the case that the reactionary leadership forced some concessions; including Bevan's admission "that he had stuffed gold into the physicians' mouths." However a service available to all (NOT FREE- if paid by general taxes) was now here.

On the Appointed Day, the Times carried a Government advert that spelt out a hidden agenda; here was the quid pro quo:

*"If we are to have these new benefits and all the goods we want ... we've got to make more goods. And we ought to find that the freedoms from anxiety that insurance will give and the better health resulting from the health service will help us to answer the call for more and more production." (32)*

One further purpose behind the erection of the new Welfare State, was not so publicly fanfared. The economic philosophy of Baron J.M. Keynes now began to hold sway. Essentially Keynes argued that it was necessary to maintain full employment in order to enable the work force to purchase the goods that they were being exhorted to produce. The story of the decline of the NHS, is the story of the failure of Keynesian economics in the 1970's to "deliver the goods" to Britain's business class.

This obviously has implications for present day strategies of health progressives and part 2 will complete the tale drawing some rather more explicit conclusions regarding the present era of anti-Keynesian Monetarism.

Haresh Kirpalani

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2. Alexander Pope. "Essay on Man" epistle 3. in (ed) A.W. Ward: Poetical Works London, 1956, p.215.



3. E. Chadwick: Report on the Sanitary Condition of the Labouring Population of Great Britain. 1847. London, reprint 1965, p.266.

4. Ibid p.264

5. Ibid p.252.

6. Ibid p.175.

7. A.L. Morton: A People's History of England p.396. London, 1974.

8. K.O. Morgan: The Age of Lloyd George The Liberal Party and British Politics 1890-929. London, 1971, p.40.

9. A.L. Morton, Ibid, p.435.

10. Naylor CD: Public Payment and Private Payment. Kingston. 1986. p.35.

11. Lloyd George cited by V. Navarro: Class Struggle, the State and Medicine. London, 1978. p.16.

12. Titmuss R.M.: History of the Second World War: Problems of Social Policy. HMSO, London, 1950.

13. Eckstein H: The English Health Service. Harvard, 1958. P.30.

14. Ibid, p.39, 57-62.

15. Ibid p.46.

16. Ibid p.48

17. Ibid p.54

18. Ibid p.61-63

19. Ibid p.116.

20. Ibid p.110.

21. Ibid .P.71

22. Ibid .p.116

23. Ibid .p.135

24. Ibid p.116.

25. Davidson B: Scenes from the Anti-Nazi war. 1980, New York p.157

26. R. Kee: The World We Fought For p.235-264. London 1985.

27. Cited by Kennedy P: The Realities Behind Diplomacy, London, 1981.

28. Ibid, p.146-149.

29. Ibid, p.149

30. Ibid, p.149

31. Kee, Ibid p.239.

32. Lindsey A: Socialised Medicine in England and Wales, Chapel Hill 1962. p.71.

## Making the World Healthier and Safer for People Who Can't Read

Twenty-five percent (25%) of Canadians are either unable or require assistance to read, write and use numbers so that they can meet the literacy demands of today's society. Surprisingly, this number does not include immigrants, native people on reserves, people in prisons or in other institutions (Southam Literacy Report, 1987)!

One of the literacy demands of today's society is to receive and understand information related to health. Thus illiteracy is dangerous – to those whose health and safety depends on their ability to read, write and use numbers.

In May of this year, a six-month Literacy and Health Project was commenced in recognition of this danger. This project is jointly co-ordinated by the Ontario Public Health Association

and Frontier College – two recognized organizations in the health and literacy fields, respectively.

The goal of this pilot project is to be able to set the groundwork for systematic attention to the relationship between literacy and health. In reaching this goal, the project takes on a dual purpose.

Primarily, it will involve identifying a network of organizations (i.e., literacy, health, government and business groups) who can identify the major health issues related to illiteracy and develop strategies to ensure that health information is being received and understood by people with low literacy skills.

Secondly in doing the above, the project will hopefully raise the awareness that illiteracy is an issue within the

health field and that one's health status is an issue within the literacy movement!

The development of a "phase two" workplan and proposal for the documentation and implementation of these strategies will be the project's end product.

If you would like to know more about the project, please contact:

Salli Abbott  
Project Manager  
Literacy and Health Project  
c/o Ontario Public Health Association  
102 Adelaide Street East  
Toronto, Ontario  
M5C 1K9  
(416) 367-3313.

## Health Related Manuscripts Wanted

NC Press Limited, a Canadian-owned publisher based in Toronto, is looking for health-related books for its new HEALTHBOOKS series.

Healthcare professionals and others are invited to submit manuscripts or proposals for popularly-written books geared to the general

public and to the busy practitioner on a wide variety of topics including: innovations in healthcare delivery, women's health care, aging, cost and accessibility, new technologies, occupational health, environmental concerns, immune system disorders and ethics.

Queries should be sent to:  
Janet Walker, Managing Editor,  
NC Press Limited,  
260 Richmond Street West, Suite 401  
Toronto, Ontario M5V 1W5



# The Medical Reform Group of Ontario, A Study of a Political Interest Group

In 1985, James Marshall McDermid approached the Steering Committee for approval of a study of the MRG. On its completion he sent us a copy, and we felt the membership would be interested in a review of its major findings.

## Theories of Group Formation

McDermid was testing competing theories about the formation of interest groups and motivations for joining them. The "environmental" theory of Truman saw man as a social being who seeks like-minded people and forms groups on the basis of shared attitudes. Groups form when habits are disturbed by social change, organize for advantage and gravitate toward state power in order to establish a new equilibrium.

Olson attacked the environmentalists, holding that man being rational, well-informed and self-interested would always choose the most benefit at the least cost. Rational man was a maximizer of personal utility (compare with the recent Massey lectures by Gregory Baum upholding communitarian against utilitarian values). Olson says that all individuals use money as a yardstick of values, and will always allow others to pay if they can. Collective goods hold little or no motivational value. Rational man will avoid paying taxes for police protection because he will benefit as much from the universal policing paid for by others. Individuals will not opt to join an interest group but take a free ride. They do join such groups because of selective incentives, coercive or attractive. They join the OMA for insurance or seminars not because it bargains for higher fees. Olson stands as a follower of the "civilised" version of a "Red in tooth and claw" pseudo-Darwinian school!

The theory applies only to "latent groups, large enough (at least 50) that individual contributions are negligible, and excludes "lost cause" groups for which he recommends psychological explanations. McDermid decides that the MRG is a latent group, not religious or a lost cause.(!) Indeed he selected the MRG for study on this very ground. It is partly philanthropic but not entirely as it supports non-fee-for-service as being ultimately, "good" for our members.

Lastly, he cites Moe who holds that members join groups for selective incentives or collective goods or both. Those who join for selective incentives tend to under-estimate their efficacy, those for collective goods to over-estimate theirs.

McDermid gives us some clues as to who forms the MRG, by analysing the reasons for joining the MRG. His questionnaire sent by mail in February 1985, received a 67% response rate. Given this it can be accepted as representative of the views of the majority of members. The following tabulates the MRG response:

Reasons for joining	% very important	% somewhat important	% not important
lobbying	90	9	1
good cause	54	33	13
feeling of responsibility	46	33	21
personal satisfaction	30	43	28
services	27	46	26
social	8	26	66

Analyzed by single items the results were:

The single most important reason for joining was political. Next was responsibility at 7%! And third social at 1%. The most valued service was the opportunity to exchange ideas. This was despite the fact that over 50% of members were also OMA members. Clearly the OMA did not nourish their brain enough.

He notes the great difficulty he had in contacting the MRG because our phone number was unlisted. We have recently been debating the wisdom of paying for a phone in our deficit position. An interesting finding he perhaps over interprets is that 80% graduated after the formative years (post 1970) of Medicare.

In summary, the birth of the MRG is explained by changes in the environment, in which groups arise in opposition to others; especially regarding issues of the erosion of equity, the rise of paraprofessionals, and a new medical ideology (I think he meant the social and economic determinants of health). In this context the MRG arose in opposition to the OMA, and the Association of Independent Physicians (AIP) in opposition to the MRG. The primary attraction was political, and most members would quit if the MRG stopped lobbying.

## New Issues

It was obvious to McDermid, at least by the end of the strike, that the MRG needs new issues or it will stagnate. He identifies some likely candidates:

1. Ageing and the need for more in-home and paraprofessional services.
2. Occupational health. He sees the MRG as having a special interest and thus an edge in this field. It is an area which will increase medical authority and thus not cause inter-physician rivalry.
3. Reprivatization, especially with free trade. We may face the re-introduction of direct charges, a decrease in insured services, and emergence of private hospitals.

Don Woodside



## “Healthy MRG 1989”

On June 19, 1988, we met for the second time to exchange thoughts and visions about where the MRG is going. Reviews of the January 29 meeting can be found in the February and April newsletters. This was a much smaller gathering: Fred Freedman, Haresh Kirpalani, Gord Guyatt, Bob James, Mimi Divinsky, Shawna Perlin, Bob Frankford, Don Woodside, and Michael Rachlis. The discussion was lively and ended up with a focus.

Resource allocation was the subject of the most heated controversy. Michael made a strong pitch for recognition of the rather meager influence of the health care system on health status, compared, say to the impact of poverty, which has recently been well-documented. Gord did not agree that treatment can be relegated to a minor position, and warned that we may be playing into the hands of reactionaries who want to cut spending. On the other hand, he felt that the issue of resource allocation was very complex. Our system would not be able to afford all the available hi-tech treatments and we would have to evaluate for efficacy. He challenged the rush to obtain, for example, MRI technology when it has no proven patient benefit.

The point was made that we should be focusing on inefficient utilization, such as long-stay patients in acute

beds. Gord said that Home Care has been proven to increase costs not decrease them, but Bob James said (later) that was because many patients got Home Care who would not have been hospitalized. Just now, Elinor Caplan is under pressure for limiting hospital spending. Where do we stand? We heard those who believe hospitals are an inefficient way to deliver most services, and those who say hospitals in Ontario are very efficient. The OMA task force report in 1984 said that the system was not underfunded, and we have agreed with that opinion in the past.

Bob Frankford, Fred and others made a plea for a political position clearly supporting a publicly owned system. We can already see new pressures for privatization, and the OMA again has called for direct patient charges. There is already private money in the system, as for example in technology and pharmaceuticals. We must define an acceptable role for it.

While we have taken a strong stand for more emphasis on prevention in the past, we have heard a number of incisive criticisms of particular prevention and case-finding programs from John Franks. Where do we stand now?

When we got to the organization of primary health care we began to see themes come together. We identified

the contradiction between our espousal of community health centres and the gradual withdrawal of our members from working in them. A lack of autonomy was the major factor. Bob Frankford talked of the CHC he recently established, with an advisory board. We noted the harm done by our practice settings, in restrictive hours and fee for service payment, and the questions about who will do primary care obstetrics. Bob James pointed out that it had taken us only a couple of hours to arrive at the same conclusion as the Grossman conference in 1983; that reform had to begin with primary health care. It was noted that we have not come out with anything as radical as Grossman himself was prepared to announce before he was bumped – a DHC managing its own budget!

We ended with talk of how to include the membership in further development of a new conceptual framework, a vision for the “post-bill 94” MRG. Perhaps it is no accident that the topic we had previously chosen for the fall semi-annual meeting is Primary Health Care. We hope that the excitement we feel is shared by others; it is only through the energy so liberated that we can move forward.

Don Woodside

## MRG Newsletter

The MRG will be undertaking a new venture shortly. This step is predicated on the notion that there are people “out there” who are interested in our views. In order to test this view, we have decided to attempt using the Newsletter as a public forum. For the first period the Newsletter will be stocked in University Medical bookshops and some selected non-university bookshops. To facilitate this, the name of the Newsletter will be amended to make it seem less parochial, or “cliquey”. Suggestions such as “Medical Reform” or “Politics in Medicine” (any ideas?) have not yet been acted upon.

There should be no fears from the membership that there will be a corresponding decline in the communication to MRG members. In our view, the three main functions of the Newsletter are:

- 1) Foster communication/discussion and policy formulation by MRG members.
- 2) Attract new members to our political positions.
- 3) Serve as a bridge to other groups whose aims are in broad sympathy to ours, e.g. National Anti-Poverty Alliance.

For us the first aim will continue to be the primary function of the

Newsletter. As far as the continued cash flow problems are concerned, the Newsletter will be increased in print number, but with a capped page number per issue. If any member has any major objections to this move, please ensure that we know by or at the fall general meeting.

There is now a functioning editorial board: Ulli Diemer, Bob Frankford, Haresh Kirpalani, Michael Rachlis, Fran Scott, Don Woodside, .

Haresh Kirpalani



## Announcements

### Workers Health Clinic Looking For Physicians

The Occupational Health Clinic for Ontario Workers (Hamilton) Inc. is a Labour-controlled non-profit incorporated clinic which will be opening in the late Fall of 1988.

The clinic is currently seeking 2 full-time physicians to work in a collective setting with other health professionals.

Applicants must be licensed to practice in Ontario and have preferably a fellowship in occupational medicine, alternatively a fellowship in community medicine or recent relevant related experience and a

knowledge of occupational and environmental health. Responsibilities will include diagnosis and treatment of work-related illness and disability, the development of recommendations to improve workplace conditions that impact on health, participation in the provision of information and education on occupational health to Labour, community groups, professionals, and other interested parties, direction of medical research activities, and supervision of the overall quality of medical services of the clinic.

**SALARY RANGE:** \$70,000 to \$94,000 plus benefits dependent on qualifications.

Further information and applications should be sent to:

Jill Marzetti,

Co-ordinator, Health & Safety Clinics,

Ontario Federation of Labour,

15 Gervais Drive, Suite 202,

Don Mills, Ontario.

M3C 1Y8

(416) 441-2731 (W) 769-7174 (H)

### Medical Director – Women's Health Centre

The Women's Health Centre of the Women's College Hospital is looking for a Medical Director who will provide medical leadership and act as a consultant and resource to the Manager in all program areas within the Centre. The Director will plan strategic goals for the Centre's role in service delivery, research and education in the area of women's health. As well the Director will initiate research projects, participate in the clinical teaching component of the Centre and provide education programs and

resources to professional and community groups. The Centre's expanded birth control and abortion referral services will also be the direct responsibility of the Medical Director.

Desireable qualities and skills include experience in Family Practice or related specialty, commitment to a holistic approach to women's health issues and multidisciplinary approaches of service delivery, proven leadership, previous involvement in health care research, experience in

program planning, implementation and evaluation.

The competition closes Friday, September 2/88. For a more complete job description and requirements list, direct inquiries to:

Subeida Ramji, Project Manager

Women's Health Centre

76 Grenville Street

Toronto, Ontario, M5S 1B2

(416) 323-7734

### Proposed Visit to Albania

I am hoping to arrange a trip to Albania to examine the health care system. Having been on two occasions previously, I feel confident that people on the trip would find it a fascinating

experience. There will be progressive physicians from the U.K., Germany, and possibly India on the trip. Cost from London U.K. about \$500. Time of stay one to two weeks, August/Sep-

tember 1989. Please contact H: Kirpalani, 131 Langford Ave., Toronto M4J 3E5, (416) 465-7480 (H), (416) 598-7174 (W).

### Membership Fees and Renewals

At its July 28 meeting, the MRG Steering Committee discussed and approved a new fee schedule for the MRG, which will be proposed for adoption at the fall general meeting. The new schedule would see the fee for physician members increased from \$125 per year to \$150 per year. Other categories of membership would remain at the same level. First-time members would still be able to join for half of the regular fee. There was discussion of a possible separate, lower, fee for residents and interns, but it was felt that this was not required. However, all members are reminded that members who cannot afford the

full fee may join at a reduced rate that they can afford.

The proposed new fee schedule is:

- \* Physicians \$150
- \* Affiliate Physicians \$50
- \* Organizations \$50
- \* Medical Students \$25
- \* Associates \$25
- \* Newsletter subscriber \$25

Membership renewal notices are mailed out in September of each year. The renewal notices which will be mailed shortly will list the new fee schedule, together with a note explaining that the increase is provisional,

subject to approval by the October general meeting.

The Steering Committee is also making arrangements to change the MRG's fiscal year, so that in the future the budget, and possible changes in fees, can be discussed at the general meeting before membership renewal time, rather than after, as is presently the case.

Members are also asked to consider becoming **Supporting Members**, by paying an additional contribution above the required fee. Supporting memberships are an important part of the MRG's annual revenue.