MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

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"MEDICINE IS POLITICS WRIT LARGE" – *Rudolf Virchow*

Schwartz Dynamite?

By Don Woodside

On November 18, 1988, the CPSO sent out a letter stating that: the licenced acts approach, which the Health Professions Legislation Review, (HPLR) is proposing as a method of regulating health care ... will effectively deregulate most health care in our province ...". This statement, and a call from the Consumers Association, prompted me to review the Review, which had presented its final report in January 1989.

Previous involvement of MRG

We have been involved with the Review almost from the outset. We recommended a permanent coordinating body which appears as the Health Professions Regulatory Advisory Council, an ongoing forum for review of conflicts between the professions and for applications by groups for regulation.

Special Meeting on Health Professions Legislation

Medical Reform Group members are invited to a meeting to discuss some of the controversial aspects of the proposed changes to the Health Professions Legislation (See above article and article on page 3 for details.) The meeting will be on Tuesday June 27 at 8 p.m., at 34 North Oval, Hamilton. Call (416) 588-9167 if you need more information.

Fall General Meeting

The Medical Reform Group's fall general meeting has tentatively been scheduled for Friday October 13 and Saturday October 14, 1989.

We wanted disciplinary proceedings to take a broader look at the institutional context in which questionable practice occurred. However, this doesn't seem practical, nor really appropriate to any one college. We supported midwives in their battle for recognition and independence. We identified a number of procedural changes (outlined in the Newsletter, February 1988) most of which have been addressed reasonably. We wanted the CPSO to stop regulating the other health professions, which it has done by virtue of its scope of "medicine". The licenced acts appears to have accomplished this.

Review 89: The Canadian Institute of Law and Medicine (CILM)

CILM hosted a conference February 3, 1989 to discuss the Review's proposals. The CPSO kindly made the tapes available to us, and a summary follows:

Gilbert Sharpe led off with the history of reviews and commissions from the early 1960's leading to the Health Disciplines Act of 1974. In 1970 they planned on 27 self-regulating professions. As they were unable to resolve disputes over scopes of practice, the Act included only the five "senior professions". The rest were to be included later. By 1980 several presented independent drafts of legislation, and the regulatory system required a more thorough overhaul, which this Review was to provide.

The "scope of practice" is the crux of the regulatory system, and Daphne Wagner of the review team described the principles for their licenced acts approach. Acts producing an "out of the ordinary" risk of harm are to be licenced: broad professional licensure is unwarranted, as portions of practice provide minimal risk and should not be restricted; status considerations should be eliminated in determining who does what. They drew up a list of licenced acts, from diagnosis to prescribing personal hearing aids, assigned them to professions according to the present standards of practice. Medicine has most licenced acts if not all, while some have none.

The potential transforming impact of these proposals was outlined in Ted Ball's presentation. He spoke to the MRG October 24, 1987 as a panelist on the Evans Report. He said studies showed that 60% of general practitioner functions could be handled by nurses, saving 10% to 25% of the ambulatory care budget. He does not go on to say, as we might, that a significant proportion of specialist functions could be handled by GPs with adequate support. He attacked the "sweetheart deals" which force the public to pay for unnecessary supervision – dentists of hygienists, physicians of audiologists. The recommendations are a tremendous improvement over the status quo, he says. The law currently does not reflect real training and competence. But it will be very difficult to proceed with these "relatively modest" reforms if the CPSO remains opposed. The report may be shelved, and we may never have a coherent system. He urged supporters to come forward.

Paul Benedetti and Mike Pettapiece, reporters for the Hamilton Spectator who did a major series on Alternative Health Care in October 1988, described their concerns about the proliferation of questionable practices. They want some onus placed on practitioners to substantiate their

claims. Freedom of choice requires informed decisions. While it may be too expensive to maintain "health police", there will be a need for much more vigorous public education about health care and about the value of regulated health professions.

A number of speakers addressed the proposed uniform procedural code. Major changes include open meetings of college councils, open disciplinary hearings (which can be closed to protect confidential evidence), complainant access to records used in discipline, and protection for professionals from the use of such documents in malpractice litigation. The changes don't go nearly far enough for the Patients Rights Association, which wants a public complaints board with patient advocates. As complaints are almost all patient-generated, for the system to function the public must perceive it as open and fair. They need help to prepare a viable complaint, and to know whether it should be directed against an individual professional or an institution or even a ministry.

Medical Reform

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

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

Deadlines: The next newsletter will appear on August 4, 1989. The deadline for longer articles is June 29; shorter items such as announcements must be in by July 17.

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

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

Editorial Board: Haresh Kirpalani, Don Woodside, Fran Scott, Bob Frankford, Ulli Diemer.

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

1. Health Care is a Right

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

2. Health is Political and Social in Nature

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

3. The Institutions of the Health System Must Be Changed

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

Licenced Acts: The Outer Boundary

The review has opted not to regulated those disciplines without a distinctive body of knowledge, Canadian training program, entry to practice standards, size, and willingness. Some, like naturopathy, will be deregulated. At the same time, the CPSO will no longer have 'medicine' as its licenced scope, and will have no grounds or reason to prosecute most of those who stray across the boundary into assessment diagnosis and advice, but avoid definitive licenced acts. Even at present, they have been only partly successful in this policing function. It seems likely that there would be some expansion of alternative health care but it would remain more limited than in the USA because of public funding of orthodox health care. There seems to be active debate on this issue lately on the radio and elsewhere. I think there is some argument for wider access to alternatives in the treatment of chronic disease. Experience in the Third World suggests that education of alternative providers is more effective than suppression. Evaluation would of course be required. As well, vigorous promotion of well-organized primary care facilities will attract most people seeking health care. The possibility remains of introducing regulation to these providers at a later date should abuses proliferate.

Internal Boundaries and MRG Perspectives

The internal boundary issue will be a much more direct concern to many Ontario physicians if it fulfills its intent of improving efficiency, increasing flexibility of task assignment in institutions like hospitals and independent health facilities, and saving money. The money saved will come from cutbacks in physician incomes or numbers.

Our third principle supports a greater role for non-physician health care workers, and we have actively supported the midwives in their bid for independent practice. A licenced acts approach ties tasks to competence, undermines traditional medical dominance to some extent, and provides an ongoing system for reassignment of licenced acts.

Some very knowledgeable people however challenge the notion that the present regulations inhibit assignment, from doctor to nurse. It was the funding arrangements that scuttled the nurse-practitioner program. They could be funded only via a doctor, and there were no offsetting reductions in payments to physicians as nurses took over their tasks. Community clinics have made extensive use of nurses as health educators. To support this line of argument, there are no substantive changes as far as I am aware in the list of acts which can only be delegated under supervision. I am inclined to think that there would be some reorganization along the lines intended by the Review, and a general loosening of professional boundaries. I therefore think that the approach has merit and offers opportunity for a transformation along the lines we have proposed, away from a doctor-centred, fee for service, private practice model.

Unanswered questions include: will it foster privatization in some way? (e.g. independent nurse practitioners, special purpose independent health facilities run by private industry). Or will it foster community health centres? Where will the money saved be spent? Is a conservative medical community the best defense against multicorp taking over, or is this the opportunity for which we have been waiting to open the system up to more community participation, and equality among health workers?

Comments on the Schwartz Commission

By Bob James

The Schwartz commission did not have an easy task. Its six-year task was none other than the total re-organization of the healing professions. The hodge-podge which had developed in Ontario over the previous two centuries had to be brought under one legal umbrella. Perhaps their task was too great for any group of people to accomplish.

I would quite agree with their idea of a standard manner by which new professions could be added or old ones changed. I think as well, that it is high time that the public had a greater access to the discipline processes of the various colleges. Of course the public's interest must be protected, even at the expense of the professions' power and incomes. For the Medical Reform Group, these cannot be issues of contention.

However, there is a concern about the idea of licensed acts. This changes radically the way in which the health professions are to be monitored. In the past, the CPSO was in effect the regulator of the entire field of health care, since it alone was able to decide what was "medicine" from the point of view of the provincial legislation. Not merely from the doctor's point of view. Those things which are felt to be capable of causing significant harm to a person, will be licensed. The rest of the field of health care could be done by whoever feels they have the training. The obvious question is "who decides what is significantly harmful?" Is counselling a potentially harmful activity? Should it be licensed? Is the incision of a cyst potentially harmful? Which diagnoses carry the possibility of harm, and thus are in the field of Medicine? And which are really not diagnoses at all? If a naturopath says that a person has osteoporosis, is that a "diagnosis" in the sense of the Act? And if he then goes on to suggest vitamin D, and the patient becomes toxic, is the naturopath then liable?

As well, there is the question of finances (always). For the community clinic, or even the hospital clinic, the Act might mean that those nurse-practitioners or social workers who are currently doing the counselling or educational work will be paid by OHIP/global funding more easily. But it could equally mean that the government, in a belt-tightening mood might say that they will only pay for those acts which are licensed to physicians – since they only want to pay for physician services. Counselling and psychotherapy, as examples, are not going to be licensed.

I think a lot remains to be done before we can wholly support this proposed Act.

Resource allocation in the health system

The featured attraction for the Friday May 5, 1989 evening session of the Medical Reform Group's Spring Annual Meeting on May 5 was a debate on the topic of resource allocation between Michael Rachlis and Gord Guyatt, two former members of the MRG Steering Committee. Over 40 people came out for the discussion.

Michael Rachlis led off by saying that there was in fact a great deal of agreement between himself and Gord Guyatt.

Rachlis maintained that what happens in the social and economic system is more important to health status than what happens in the health care system.

He said that the health care system is inefficient, but pointed out that one has to be careful in how one uses terms like efficiency. To set the context, he noted that we want health for what it gives us, not for itself, and also pointed to the dichotomy between health care and health status.

There are, he said, two types of efficiency. The first is technical efficiency, implying "the least quantity of inputs for outcome". The second kind is "allocative": the best mix of goods and services. This kind asks the question, "Would it be better to do something else instead?"

Rachlis summarized his views on a strategy for health allocation by proposing that resources should be allocated to reduce inequalities in health status. This implies equal access to health care, and the equal right to live in a healthy society.

He acknowledged that there is a danger that talking about inappropriate and inefficient care can be used as a justification for cutbacks in health care.

Rachlis concluded by stating that physicians in the MRG are uniquely positioned to participate in the debate and to argue for reallocation of resources.

Gord Guyatt also noted that there were many points of agreement between himself and Michael Rachlis. He said that the area of disagreement relates to what is the political environment and how should we act in the crisis that has been created. What should be the emphasis of our positions and how should they be balanced?

He agreed that the broad determinants of health (economic and social factors) were more important than health care, especially "at the margin". This kind of thinking, he said, is becoming increasingly accepted, and may be heard from government spokespeople or at meetings of the McMaster medical faculty executive.

The question, according to Guyatt, is whether the government and others are actually saying 'let's allocate resources more effectively', or

whether they are *really* saying 'let's cut back on spending in the health care system.'

On the other side of the debate, is the OMA saying 'patient care is important' or is it really saying 'let's protect MDs' jobs and income'?

Canada spends 8 1/2 per cent of its Gross National Product (GNP) on health care. By comparison, the United States spends 11 per cent of its GNP on health care. This, said Guyatt, gives Canada a 2 1/2 percentage-point edge in trade.

The question is being posed as 'can we afford health care?' or 'can we afford social services?'. It could also be put as 'can we afford corporate profits or personal luxuries?'

The crisis atmosphere, said Guyatt, is being created to establish an atmosphere which will get people to accept cutbacks. There is a danger in playing into the hands of the government and the corporations under these circumstances. We should be very careful in talking about inefficiencies. We should argue in favour of *more* spending on the right kind of health care. There are plenty of extra ways to spend more money on health care and get something out of it.

In the discussion which followed, **Michael Rachlis** said that the answer to the danger pinpointed by Gord Guyatt is not to be quiet on the inefficiency issue. We should attack policies that create more structural economic inequalities. A more unequal tax system will kill people. The OMA for its part wants to ensure that doctors are still calling the shots in the system.

Gord Guyatt said that there is a genuine danger of cuts that will hurt people. There is no guarantee that the areas cut back are the areas *we* think ought to be cut back. And if resources are taken out of the health care system, there is little chance they will go to the things we believe should be the spending priorities. There is a real risk of not enough being spent on health care.

Clyde Hertzman wanted to know in what sense there have been cutbacks in health care, if health care spending has been more or less constant at 8 1/2 per cent of GNP in the 1980s.

Gord Guyatt said that from his own experience he was aware of areas in which spending was not keeping up with need, although in other areas in might have been increased substantially and perhaps unnecessarily. He said that it is harder to get hospital beds, and there are waiting lists for surgery. He also noted that some very expensive procedures do save lives.

Michael Rachlis said that the 8 1/2 per cent average contains some significant disparities. In Ontario, spending has greatly outstripped growth in the economy, by perhaps 30 per cent. In other provoinces, such as Alberta, this has not been true. In Ontario, there are all sorts of doctors in private practice, walk-in clinics. What do they do? They only see healthy people and take home $100,000 per year! The proportion of spending going to physicians has 'exploded'.

Phil Hebert said that we should ask what effectiveness is and what efficiency is. Some very questionable assumptions underlie these economic categories and the decisions they lead to. What constitutes a benefit or a burden is a question that contains a moral dimension. We can't make these decisions using only 'economic' criteria. The utilitarian theory on which this economic approach is based is just one form of moral philosophy; there are many others.

Michael Rachlis gave as an illustration the question of what are the moral benefits of allocating resources to poor children versus allocating them to rich old men. He suggested that health care spending places too much priority on 'rich old men'.

Gord Guyatt said that we don't need to worry about advocating for coronary bypass surgery – there is an effective lobby to do that. We need to advocate for home care, palliative care, psychiatric care, etc. These are not being advocated for.

John Frank said that every time something is stopped, or we advocate that something be stopped, we should also be saying what it should be replaced with.

Bob James said that we should be looking at socializing more of the health care system. For example, the private lab system and the private nursing home system. By socializing these, we could save money which could be put back into the health care system where it is needed. Real savings could be accomplished in getting rid of capitalist influences in the health care system.

Michael Rachlis pointed out the private drug companies drain huge amounts of money from the health care system. He also noted that physicians' salaries have gone from 24 per cent to 32 per cent of the health care budget. He said we need to control the number of physicians being produced – the growth rate in the number of physicians is outstripping the population growth. He also proposed that the University of Toronto undergraduate medical school be closed.

The question was raised of whether putting physicians on salary would cut costs.

Gord Guyatt said that there is no magic solution to how you pay physicians. Any way has its problems. He suggested that the existing fee-for-service system could be used to influence and change the ways doctors practise.

Clyde Hertzman said that in British Columbia, they negotiate the total budget as well as doctors fees. If total billing starts going over the budgeted amount, they start paying 95 cents on the dollar. (Someone pointed out that this had the disadvantage of penalizing doctors who practise responsibly as much as those who don't.)

Haresh Kirpalani asked what the Medical Reform Group is doing that academics aren't. A lot of what the MRG is saying academics are also saying. We need to translate our ideas into a political program. Simply positing alternatives is not going to be effective. The MRG needs to establish links with other groups; e.g. poverty action groups and unions. The MRG needs to push a socialist perspective of health care. There is a lot of misdirected money, but it's a naive approach to think that our views can be translated into policy by just stating them without alliances with other groups.

Philip Berger said that politically much of the perception of crisis was created by the Ontario Medical Association, which has consciously been pumping out stories about the crisis in health care. Doctors, he said, are never evaluated on effectiveness of what they do. He quoted Bob Dylan, who said that a lot more people die in universities than in old folks homes.

Bob Frankford said that capitation is a very positive way of reallocating resources.

Fred Freedman said that other social services should be evaluated; they also waste.

Gord Guyatt said that one can't simply say that high tech bad,, primary care good. Some high tech is very good, and some primary care is very bad.

Michael Rachlis said that we need to set some health goals. Then one can evaluate different ways of trying to achieve them.

Phil Hebert said that there is no uncontentious way of agreeing on goals.

Fred Freedman said that we can't hope to reform the medical profession from within, given the conservatism and elite social background of much of the medical profession. Is the MRG a doctor-oriented group or a group oriented to the public? Are we going to be reformist or radical?

Re-allocating Resources for Health

MRG Statement of Principle

The following statement was passed at the Medical Reform Group's May 1989 General Meeting:

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[1]

Universal access to high quality, appropriate health care is one guarantee of this right, and adequate resources should be allocated to health care to protect this. However, health is political and social in nature, and it is essential that adequate resources are directed towards the eradication of social, economic, occupational and environmental causes of disease. The following principles form the basis upon which decisions should be made regarding the allocation of resources to promote and protect the highest attainable standard not just of health care, but of health status.

1) **Perspective** – Decisions regarding the allocation of health care resources and other resources in relationship to health must be viewed broadly; i.e. within the context of how society allocates its resources in general. Since public policies unrelated to health care have major impacts on our health, health may be improved more by spending money to correct the political and ecomomic roots of ill health – outside of the health care system – than by spending money on health care. At the same time, health care spending and the allocation of resources to promote and protect good health should be examined in relationship to total societal resource allocation, not just government spending.

2) **Equality** – all people should have equal opportunity to live in a healthy physical and social environment, as well as equal access to health care. Reducing inequalities in health status, not just access to health care, should be the highest priority in deciding how to re-allocate resources for health.

3) **Effectiveness** – Health care interventions, including organizational policies, and health protection and promotion interventions should be supported only if there is evidence that they improve the length or quality of life. The extent of the evidence that is required should be determined relative to the magnitude of the potential benefits, the risks and the costs of the intervention. Impacts on health status – i.e. well being, not just physical health – should be the primary measure of effectiveness. Because the potential to measure impacts on health status varies with the nature of the intervention, evaluations of effectiveness should be appropriate to the nature of the intervention. Both existing and new interventions should be evaluated.

4) **Efficiency** – Resources should be allocated to achieve the maximum benefits possible relative to the resources expended. The viewpoints that should be taken in considering tradeoffs should be those of society as a whole and the individual patient, rather than the viewpoint of those funding or providing health care.

5) **Re-allocations** – Re-allocations of resources should be directed towards the improvement of health, rather than to such things as military spending or excessive corporate profits. Decisions regarding the re-allocation of resources should be made from a societal viewpoint, should be based on evidence of effectiveness and, most importantly, should result in an equitable as well as efficient distribution of resources.

1. Constitution of the World Health Organization, adopted by the International Health Conference held in New York from 19 June to 22 July 1946, and signed on 22 July 1946 by the representatives of sixty-one states (Off. Rec. Wld Hlth Org. 2, 100)

A National Health Program for the U.S.?

Article Review: "A National Health Program for the United States". Reference: New England Journal of Medicine 1989; 320; pp 102-108

An article in the New England Journal of Medicine, written with the endorsement of 412 American physicians may represent an important milestone in the development of comprehensive national medical care.

To quote the abstract:

"Our health care system is failing. Tens of millions of people are uninsured, costs are skyrocketing, and the bureaucracy is expanding. Patchwork reforms succeed only in exchanging new problems for old ones. It is time for a basic change in American medicine. We propose a national health program that would (1) fully cover everyone under a single comprehensive public insurance program; (2) pay hospitals and nursing homes a total (global) annual amount to cover all operating expenses; (3) fund capital costs through separate appropriations; (4) pay for physicians' services and ambulatory services in any of three ways: through fee for service payments with a simplified fee schedule and mandatory acceptance of the national health payment as the total payment for a service or procedure, through global budgets for hospitals and clinics employing salaried physicians, or on a per capita basis (capitation); (5) be funded, at least initially, from the same sources as at present, but with all payments disbursed through a single pool; and (6) contain costs through savings on billing and bureaucracy, improved health planning and the ability of the national health program, as the single payer for services, to establish overall spending limits. Through this proposal we hope to provide a pragmatic framework for public debate of fundamental health policy reform.

As an indication of the seriousness given to the proposal, the same issue of the journal has an editorial, signed by Dr. Arnold Relman, its Editor in Chief, entitled "Universal Health Insurance: Its Time has Come".

The article uses Canada as an example extensively. It is reassuring to find that there is a growing realisation in the US that a universal, state sponsored health system is cheaper, more equitable and a pleasanter environment in which to work. Superior as our system is at the present time, one would wish to remind our colleagues that an inadequately planned system with virtually open ended funding of physician remuneration contrasting with constrained and unpredictable funding in other areas is also increasingly faced with the need for reform.

Robert Frankford

Book Review: "Second Opinion"

Second Opinion, by Michael Rachlis and Carol Kushner, Collins, 1989, 372 pp, $ 26.95
Reviewed by Fred Freedman

It's with a little trepidation that I write a review of 'Second Opinion'; I guess because of my political connection with Michael through the MRG. It is, of course, easier to criticise than to offer solutions...but then, if I thought I had the solutions, I too would have written a book.

I think the book does a major service in that it offers a 'wholistic' approach to examining the health-care system in a popular format. The question and answer and anecdotal approach used, although occasionally affectatious, does make the book an easy read. In particular, I really like the chapter describing the scientific method. I'm not sure I've ever seen it attempted in this type of book and it is a prerequisite for an understanding of how apparently scientific decisions may not be rational.

There were several specific items that irked me. I'm afraid the authors themselves can be accused of statistical inconsistencies. The book suggests percentage of GNP as the appropriate way to look at whether health-care spending has kept pace with inflation. In the same chapter, however, changes in spending between provinces are compared without reference to the relevant 'gross provincial products'. As well, doctors' incomes are described as rising 400% over a given time period but no comparison is given for the average industrial wage.

I strongly object to the widespread use of American figures. I'm not sure their system has much to emulate, although I know I shouldn't let nationalism flavour my politics. Using U.S. comparisons is a double-edged sword. While perhaps the chaotic consumerist society of the U.S. has allowed for more experimentation (because of economic necessity) let us not play into the hands of the right in Canada. This right seeks to use the U.S. as an example in order to further demands for privatisation.

The section 'Lessons from America' lauds this consumerist mecca as an example of democratisation of the health-care system. While it can sometimes appear 'progressive', proliferation of product choice is, of itself, not. Surely more types of breakfast cereal on the shelves of Loblaws does not represent popular power.

Any comparison of the role and value of different health-care workers must be based on more than just economics. I think the authors' attempt to ensure 'value for money' in the system leads them down the road of mere 'economist' analysis. In a fragmented and uncaring society, I as a family doctor, often feel myself in the role of extended family member or

clergy. I think that a purely economic analysis of my role may find that I could be replaced by a cheaper substitute but I feel that my role has a value beyond dollars and cents--as a coordinator and advocate for my patients.

One of my concerns about Michael's analysis of health-care has been that he tends to 'doctor-bash'. While he keeps himself admirably under control in this book, I think his tendency to ascribe all things evil in the system to physicians is simplistic. The other side of the coin is, of course, that nurses are pure as driven snow and, equally, the saviours of the system.

In terms of 'what is to be done', I think the book becomes weaker. The authors suggest $12 billion could be trimmed from health-care spending nationally. They suggest alternate uses for these funds. I, by the way, do not subscribe to the theory that attacking the system for its waste and suggesting that health-care may in fact be adequately funded already, plays into the hands of the right. I think that failure to attack any system which is irrational can never serve the left's cause. Surely demystification of the present system is a prerequisite for any discussion of a rational successor. In this process we all move ahead. This point is the crux of my appreciation of the book. I think it will stimulate thought among the general public and provide insight into the difference between health and health-care. That may be the most potent way to break the power not only of the medical establishment but the economic-political one as well.

It's political conclusions I find disturbing. No one, I think, can argue with the establishment of District Health Councils 'democratically' thrashing out the needs for health and health-care locally. The mention of an impending HMO run out of The Toronto Hospital Corporation as a promising development worries me.

There is nothing in the final chapter that I think the provincial Liberal government could not endorse (if it woke up long enough to read the book). I don't mean to suggest that we are living under the regime of a secretly progressive government. I think the book eventually draws to a conservative or reformist conclusion.

There is no talk of power structure. For example, the authors suggest we could develop a formulary with a limited number of drugs. They suggest pharmacists would support the measure in spite of the potential of lowering their incomes, because it would enhance their professional stature (have the authors not learned their own lesson about the medical profession?). They go on to say the public would support it because it is rational and besides, they hate the multinationals anyway (did I sleep through the debate on Bill 22?).

I'm also not certain that giving $1000 to each single parent would ultimately change the structure. I'd suggest we either dispense with almost the entire social service and give for instance $5000 to each poor person (at least that's enough to make a difference and then we wouldn't need all the social workers), or preferably restructure the political economy so as to meet the needs of those producing wealth.

My last criticism is that the authors let the media off the hook easily. Their criticism of the poor analytical quality of reporting of health issues is mild. But again, without a more global political analysis, maybe they couldn't go further.

I'm glad I read the book. I learned a fair bit of specific details and was once again reminded of the limited role of the system of which I am a part. As an introduction the book fares well. But I'm left feeling that an analysis that would lead to political action is beyond this particular volume.

This book is obviously of importance to the MRG readership. Therefore a further review will appear in the next issue, written by Sandy McPherson.

Book Review: Worse Than the Disease

Worse than the Disease: Pitfalls of Medical Progress. Diana B. Dutton. Cambridge University Press 1988

Reviewed by Robert Frankford

Diana Dutton writes from a background of medical sociology and social policy analysis. This book is a timely and useful contribution to current discussions of resource allocation and many related issues. She centres her discussion around chapters on the history of four particular issues. These are the drug DES (Diethyl Stilboesterol)and its use, the artificial heart program, swine flu immunization and the introduction and control of genetic engineering. The histories are useful summaries and give useful insight into the actions of doctors and other of society's institutions. The enthusiasm with which the new 'advances' in the areas discussed were greeted may seem almost quaint now, but the unrestrained optimism continues in new areas. The DES story is clearly one of a cure in search of a disease. The pharmacological effect of a new compound seemed to demand therapeutic application. Experts proposed its use for preventing spontaneous abortions and its prescription became widespread. In 1952 properly conducted trials indicated that the drug was ineffective but authorities of the day who had established their reputations around the drug chose to defend their position with selective statistics. Only in the late 60s did careful epidemiological studies establish the drug's link with vaginal cancer in those exposed in utero.

The artificial heart and the swine flu program are good examples of expensive programs promoted with great enthusiasm by government agencies and politicians, whilst overlooking the disadvantages. The chapter on genetic engineering is on a topic where there is not a clearly established position on risks and benefits, but it an interesting study of society's decision making processes.

The Medical Reform Group has made resource allocation one of its current areas of discussion. Dutton makes a useful list of factors that have a strong influence in decision making leading to these examples of poor resource allocation. She lists technological optimism, underestimation of risks, suppression of doubt and dis-

sent, a fragmentary and myopic view of problems, assumption of unlimited resource and inflexibility of decisions once made. Another topic, discussed at the May meeting of the Medical Reform Group is medical liability insurance and the possible introduction of no-fault compensation. Dutton's examples contrast the enthusiasm with which innovations were introduced with the extreme difficulty of obtaining compensation for the injured. A strong case is made for much better disclosure of risks combined with much greater recompense from society. Little change has taken place to make one believe that lessons from Dutton's examples have been noted. To oversimplify her solutions, one might say that small is beautiful and greater public participation (and she comments favorably on activist organizations such as DES Action) much to be desired.

The following is an extract from her book while illustrating some of her views on the artificial heart.:

The Artificial Heart

The summary report of the first-phase contract feasibility studies, prepared by Hittman Associates (sic), a systems-oriented program contractor was released in early 1966... The six subcontractors had each made estimates of the need for the artificial heart, ranging from between 10,000 and 500,000 new cases annually; the Hittman consultants threw out the highest estimate, averaged the others, and came up with a specific figure of 132,500 cases per year. When it came to calculating costs and benefits, they simply assumed that all implantations succeed without any operative deaths, and that recipients would return to normal and, on the average, live longer and healthier lives that other people because they would no longer be at risk of heaving heart disease. There was no talk of confinement to an intensive care unit, being dependent on a ventilator or enfeebled by a stroke; patients would have the operation, recover and get up and walk out of the hospital. Thus rehabilitated, according to the report, these patients would return to the work force and add $19 billion to the GNP during the first decade of the artificial heart and another $41 billion during the second decade. The Hittman consultants estimated that the average cost would be about $10,000 per patient and optimistically said that taxes paid by recipients would more than pay for the entire federal program.

– from *Worse than the Disease*

Radical Deficit Cutting.

By Haresh Kirpalani.

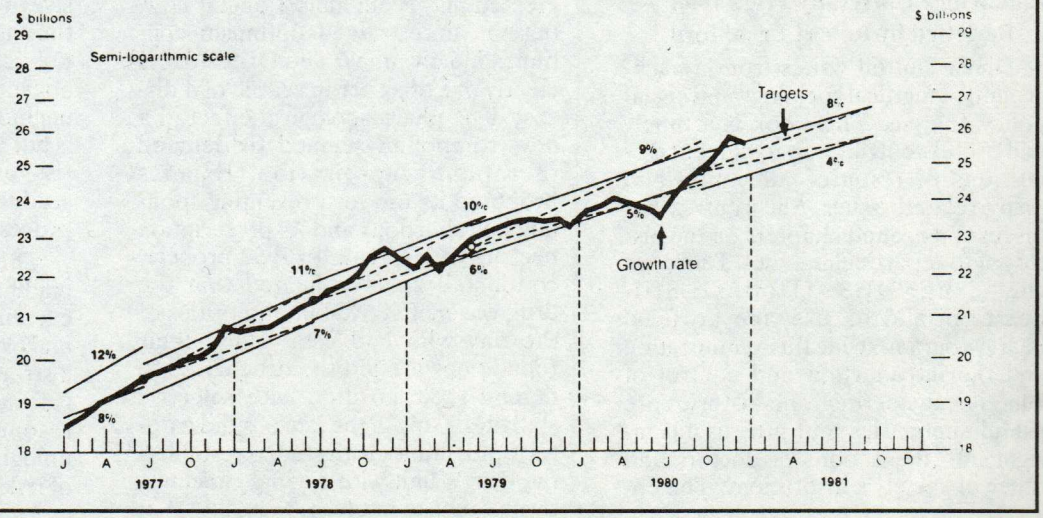
Several times in the Medical Reform Group's Spring meeting the issue of the deficit came up, influencing the tenor of the meeting. This perspective contained here is not well advertised in the media, but may be relevant. If it is true that the national deficit is of such proportions that social programs including health care have to be cut, then it becomes imperative to ask some basic questions about the deficit such as how it got to be so high, and how it can be brought under control, and to whom is it owed.

It is commonly accepted that after the war it was necessary to expand the economy. To do this Keynesian economic doctrine was followed – dictating that to stimulate the economy it was necessary to enable the population to actually buy the goods produced. To stimulate investment, injection of money by printing or by borrowing was advocated. This is called deficit financing. This policy continued until very recent times. (See graph 1-ref 1)

For a period this indeed achieved the objective of growth of the economy, or gross national product. Whilst ability to repair war time deficiencies and damage, and whilst there was still a realignment in world trading (from British dominated to US dominated) investment booms occurred. For example in steel, autos, aircraft. But all

Money Supply Targets and Money Supply Growth Rate

Source: Fig. VI, Catalogue 11-003E, Vol. 55, Statistics Canada

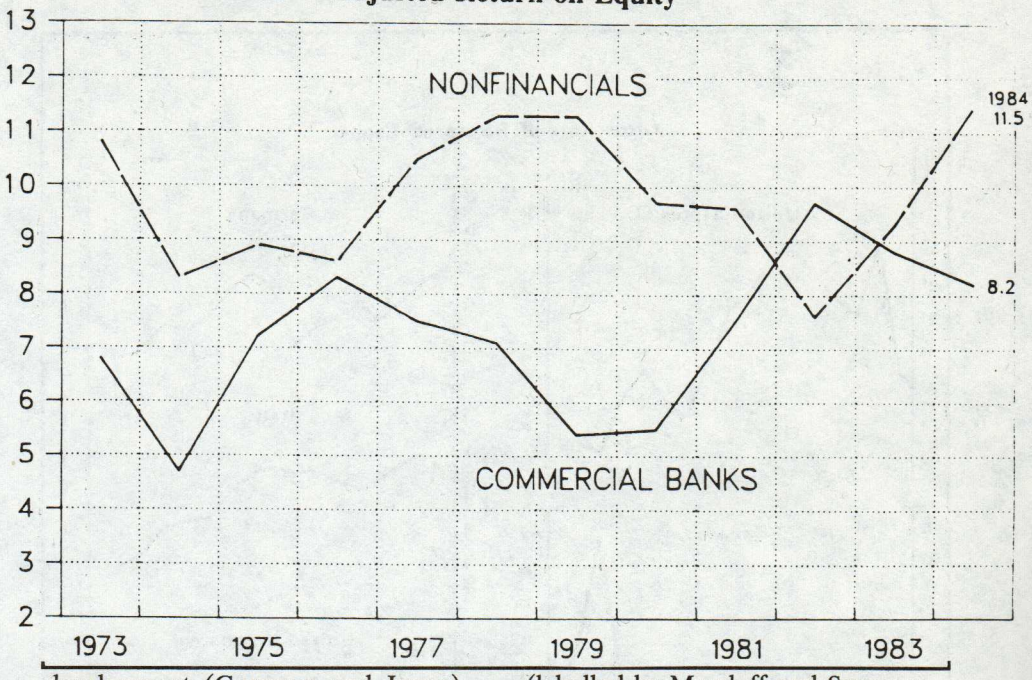


the money injection resulted in inflation.

To whom has inflation been a problem? Workers and those on fixed incomes will respond to inflation by striking and agitation. This does not please either bankers or industrialists. Nonetheless since prices are always ahead of wages profits are preserved. However it is unacceptable to financiers and financial institutions, which obtain their profit by lending in return for interest or dividends. Graph 2 shows the inverse relation between banking and non-financial business(2).

Monetarists were impelled by this logic into powerful advisory positions. They for a period commanded Thatcher and Reagan's ears. Under their advice, money supply was choked off relative to the previous years. This temporarily halted inflation but also resulted in under investment in industry. This was an international phenomenon: The industrial world has entered a period of investment slowdown that will affect international trade, industrial production and unemployment (3). So investment in industry has been markedly curtailed. Particularly since the Keynesian deficit financing had resulted in over capacity. As competition for markets stiffened only those that spent more on research and development (Germany and Japan) were able to offer a "better deal" as their unit price of production was lower and so their exports could win out.

Inflation — Adjusted Return on Equity



Damned if one does and damned if one doesn't -could sum up the position of the capitalist state. Keynesian deficit financing had stimulated the economy, but at the cost of inflation. Monetarism had controlled inflation, but at the cost of depressed industrial investment and rising unemployment. This situation was especially critical since over a longer period than covered by figure 2, profit fell steadily. OECD figures for 9 countries including Canada show this clearly (figure 3-ref 4). The rise in Canadian profits from 72-74 reflects the rising prices of raw materials, especially oil. But since 1974, Canada's share of the world market for raw materials has fallen by 15% precipitating a fall in Canada's profits(5).

To cap it all, despite the monetarist clamp on injection of the money supply by Governments world wide, control of inflation was only temporary, it reaming a problem. Why is this so? The advent of computerised trading and the deregulation of the money markets, junk bonds, future trading, new forms of credit has sent "hot money" chasing all over the world for a profit. Banks are joining in this chase have also become borrowers! This means that the net effect is an increased circulation of cash-thereby boosting the money supply. As the Federal Reserve Bank of New York (labelled by Magdoff and Sweezey – the "horse's mouth") says: "New financial instruments -such as futures, options and swaps . . . has burgeoned. The volume of financial transactions has accelerated at an unprecedented rate"(6). This basically defeats the governmental planners. It also explains the insistence on such high interest rates which in themselves fuel high profits for money lenders.

To whom does Ottawa owe the deficit? See table 1 (7). It is primarily a host of Canadian financial institutions, though 19% is to foreign non-Canadians.

Where does all this lead? It is not enough in my view to simply view the deficit in isolation from the essential question of "Who runs this country and for whom is it being ruled?"

The primary problem for the capitalist class as a whole is the tendency of the falling rate of profit in the post war era. The primary problem for the industrialist capitalist is to get investment cheaply for his factory. The primary problem for the financier is to prevent inflation from whittling away his future dividends.

It is my contention that it does not behove the progressive to fight the deficit on the terms offered by the ruling class. These are: "Accept the status quo and division of profits, and allow us to depress your standard of living and ultimately your social welfare rights."

Who holds Ottawa's Debt?

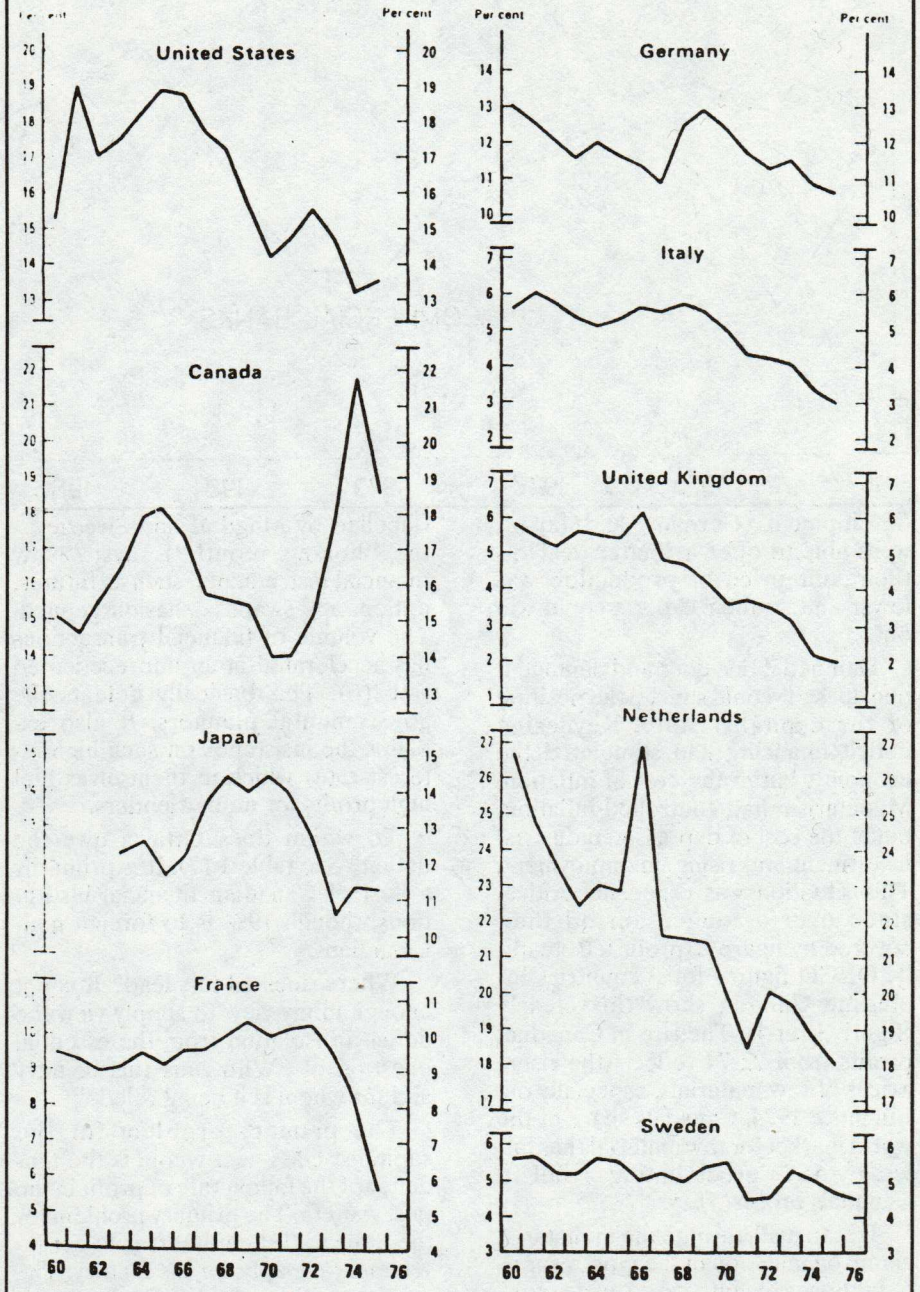
Canada Savings Bond Holders	20.1%
Bank of Canada	7.8%
Other Federal Agencies	1.8%
Chartered Banks	6.4%
Trust Companies	1.4%
Mortgage Companies	1.4%
Investment Dealers	3.2%
Credit Union and Caisses Polulaires	1.0%
Insurance Companies	6.9%
Pension Funds	8.4%
Non-Financial Corporations	2.6%
Provincial Governments	4.8%
Municipal Governments	0.6%
Individual Canadiens	12.1%
Non-Canadians	19.0%
Total	**98.0%**

Note: Percentages do not add up to 100% because of small holdings by other institutions.

Source: Bank of Canada Review, Feb. /89

GRAPH 3

Gross Rate of Return on Capital



Source: OECD, *Towards Full Employment and Price Stability*, 1977

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2. from Epstein, in "The Imperiled Economy – macroeconomics from a Left perspective." New York, 1987

3. Canadian Council on Economics. "Strengthening Growth", Ottawa, 1985

4. From "Is the Canadian economy closing down?" F. Caloren, M. Chossudovsky, P. Gingrich. Montreal, 1978

5. Bernstein and Schembri: "Canada among nations." 1986. Toronto, 1987

6. Cited in: H. Magdoff and P. M. Sweezey. "Stagnation and the financial explosion." New York 1987.

7. From Carol Goar, Toronto Star 9. 3. 89

News Briefs

Supreme Court refuses to rule on fetal rights

The Supreme Court of Canada has refused to rule on whether a fetus has rights. In a 7-0 ruling, the court said that since there is no abortion law in Canada, Joseph Borowski's attempt to have fetuses declared citizens endowed with a constitutional right to life and to equality raised a moot point. The court said that to decide the case would have meant intruding in a policy area reserved for Parliament.

-March 10, 1989

Abortion clinics banned in Nova Scotia

Nova Scotia's Progressive Conservative government has outlawed freestanding abortion clinics in the province. The province's health minister said that abortions in the province can only be performed in provincially approved hospitals. However, Dr. Henry Morgentaler announced four days later that he would set up a Halifax abortion clinic in defiance of the Nova Scotia regulations. The regulations "clearly endanger the security of women," he said. "This is an enormous abuse of power which should not, and will not, go unchallenged."

-Globe and Mail, March 17, 1989, Toronto Star March 21, 1899

New Brunswick abortion policy toppled

The New Brunswick government's abortion policy, under which the procedure was covered by medicare only if two doctors certified that it was medically necessary and if it was performed in an accredited hospital by an obstetrician or gynecologist, has been struck down by the Court of Queen's Bench. The law was challenged by Dr. Henry Morgentaler, who was refused medicare payments for three abortions he performed on New Brunswick women in Montreal.

-Toronto Star & Globe and Mail, April 15, 1989

Morgentaler clinic wins injunction

Toronto's Morgentaler clinic has won a court injunction that bans picketing within 500 feet of the Harbord Street clinic. The injunction was ordered May 5 by Mr. Justice M. A. Craig of the Ontario Supreme Court, who found that the daily anti-abortion picketing poses a risk to patients and amounts to intimidation. The injunction is to remain in force until a lawsuit by Dr. Morgentaler against some of the picketers comes to court. However, both Dr. Morgentaler and his lawyer, Clayton Ruby, have admitted that the injunction itself was the clinic's main objective.

- Globe and Mail, May 6, 1989

AIDS advisor resigns

Dr. Norbert Gilmore, the chairman of the National Advisory Committee on AIDS since its inception six years ago, has resigned. He linked his resignation to government measures which he said impaired "the Committee's ability to act independently without government interference." AIDS activists regretted his departure, saying Gilmore has been instrumental in guiding the debate over how to fight the disease in Canada. "Gilmore commands widespread respect across the country," said Dr. Philip Berger. "This means there will be a total vacuum of leadership. Nationally, he was the only figure who tried to provide leadership. It's a real loss."

-Toronto Star, April 12, 1989

Anonymous AIDS test clinics backed

Toronto's Board of Health has changed its policy to come out in support of clinics where people can be testing anonymously for the HIV virus. Under current Ontario law, no one is supposed to receive an AIDS test anonymously, and positive results are supposed to be passed on the local board of health. However, some doctors and clinics have been quietly ignoring the law. Anonymous testing has met with resistance because it would permit AIDS-infected people to disappear back into the community. However, AIDS activists told the Board that many people simply don't get tested because they fear their names being made public. Dr. Philip Berger told the Board that "it is better to get tested and counselled anonymously than not to get tested and counselled at all."

- Globe and Mail, April 6, 1989

Public Trustee sues hospital unions

The Quebec Public Trustee has launched a law suit against hospital unions on behalf of mentally handicapped residents of a chronic care hospital. The suit alleges that when the unions went on a 33-day 'illegal' strike five years ago, they caused residents of the hospital to suffer emotional distress and insecurity. $10 million in damages are being sought. Three unions whose members took part in the strike – the Confederation of National Trade Unions, La federation des affaires sociales and Le syndicat national des employes de l'hopital St. Julien are being sued. The claim of emotional harm is partly based on the premise that the residents were deprived of contact with the only people who are a constant in their lives.

- Globe and Mail, February 27, 1989

Quebec MDs reject 'smart' cards

The Quebec Federation of General Practitioners has rejected a proposal from the provincial minister of health to issue 'smart' cards to Quebec residents for their health care. The proposed cards would contain a microchip which would store a patient's health records, including medical history, medical treatments received, etc. Dr. Clement Richer, president of the doctors' group, said that "the dangers of abuse are too great. Imagine if an insurance company or an employer got access to your file. It could be devastating."

-Globe and Mail, May 13, 1989

OHIP to be replace by payroll tax

The new Ontario budget contains a plan to eliminate OHIP premiums and replace them by a payroll tax. Eliminating premiums was one of the Liberal government's election promises. The move was opposed by Dr. Henry Gasmann, the outgoing president of the Ontario Medical Association, who said that he fears that government could divert tax dollars, now spent on health because they come from OHIP premiums, to other things. The Medical Reform Group's position, adopted in 1979, is that "OHIP premiums be abolished and funding for health care come from progressive forms of taxation."

C.H.O. pilot project

The Ontario government will spend $8 million over the next three years to set up Comprehensive Health Organizations (C.H.O.s) as pilot projects in several municipalities. C.H.O.s are non-profit corporations which receive funding on a capitation basis. Physicians will be paid by the C.H.O., rather than by billing OHIP. According to Ontario Health Minister Elinor Caplan, the province hopes to enroll five per cent of Ontario's population in C.H.O.s within five years, and 15 per cent within 10 years. C.H.O.s might operate differently in different communities, she said. For example, in one place it could be independent from the local hospital and arrange hospital services through contracts; in another place, the C.H.O. might be directly linked to a particular hospital.

-Globe and Mail, April 6, 1989

Health Goals for Ontario

The Premier's Council on Health Strategy has issued its first paper on health goals for Ontario. The council is recommending that the government adopt these goals as a first step in setting a broad agenda for health. The goals are listed under five headings: "Shift the Emphasis to Health Promotion and Disease Prevention", "Foster Strong and Supportive Families and Communities", "Ensure a Safe, High Quality Physical Environment", "Increase the Number of Years of Good Health for the Citizens of Ontario by Reducing Illness, Disability and Premature Death", and "Provide Accessible, Affordable, Appropriate Health Services for All".

Health Survey

The Premier's Council on Health Strategy is launching a health survey of 52,000 Ontario residents this fall. The survey, designed by the Ministry of Health, will gather information about present health status, health risk factors, the impact of health problems and awareness of health issues. The data is to be used to produce health profiles of various age/gender groups and to give a "snapshot" of the current health of the population. The intention is to repeat the survey every few years to document changes in the population's health status. Information collected will be kept confidential, but a summary of the findings with no identifiers will be made available.

MDs seeking to incorporate

Three Ottawa doctors have initiated a court case challenging the provision in the Ontario Health Disciplines Act which prevents physicians from incorporating. They are invoking the Canadian Charter of Rights and Freedoms in claiming that the legislation discriminates against them. The Ontario Medical Association, which has been lobbying for professional incorporation for 15 years, supports the case in principle.

-Globe and Mail, March 23, 1989

Who's Paying for Medicare?

The Canadian Health Coalition (CHC) has issued a discussion paper raising concerns about impending cutbacks in federal transfer spending, and also about the way some provincial governments are spending medicare funds. The paper points out that the federal share of health care spending has fallen from 45 per cent in 1977-78, to 38 per cent in 1988-89. The CHC also argues that "if corporations paid their fair share not only could we adequately fund current Medicare programmes but we could afford major improvements in Canada's health and social programmes." It urges that Canada's medicare system not be victimized by concern for the federal deficit and strategies to cut transfer payments.

-Canadian Health Coalition, April 17, 1989

Ontario cuts list of subsidized drugs

About 1,400 of the 1,600 drugs and other health products that have been free to senior citizens and people on social assistance under the Ontario Ministry of Health's Special Authorization Program will no longer be free after June 30. About 200 products, including two AIDS medications, *Acyclovir* and *Ensure*, will remain eligible for government coverage. The Special Authorization Program enabled physicians to receive authorization for drugs not listed in the Ontario Drug Benefit Plan formulary. The Ontario Drug Benefit Plan formulary remains unchanged. The Lowy Commission on Pharmaceuticals in Ontario had recommended that the list be trimmed.

-Globe and Mail, April 4, 1989

Hoffmann-La Roche fined

Hoffman-La Roche Ltd. was fined $50,000 in April for breaking the federal competition law. The company pleaded guilty to price maintenance, or influencing the price at which its products are sold by client firms. In 1985, the company offered a discount to a Saskatchewan wholesale co-operative, United Pharmacists Enterprises, on condition that it agree not to resell the product at less than the standard price. United Pharmacists refused to sign such an agreement, and Hoffman-La Roche retaliated by refusing to offer its standard discount on purchases.

-Globe and Mail, April 5, 1989

Workers' Compensation Boards upheld

The Supreme Court of Canada has upheld a law which bars injured workers from suing their employers. In a 9 - 0 ruling, the court said that the Newfoundland Workers Compensation Act does not violate the Charter of Rights and Freedoms by preventing workers from suing their employers for damages in workplace accidents. The ruling pleased unions officials, who had feared that the workers compensation system would be undermined by an explosion of lawsuits, with workers suing employers and each other for negligence, and employers counter-suing their employees. The existing system is in essence a no-fault system. The case had been brought to court by Shirley Piercey, whose husband was electrocuted in 1984 at the General Bakeries Ltd. plant where he worked. Mrs. Piercey contended that the company was responsible for her husband's death, and that she should be allowed to sue it.

Labour spotlights workplace deaths, injuries

The Ontario Federation of Labour (OFL) has erected a billboard in front of its headquarters to publicize the toll of workers killed and maimed on the job. As of the end of April, 91 workers had been killed and 117,936 injured in Ontario, according to the OFL. In 1988, 293 workers were killed and 489,819 were injured in workplace accidents.

Multicultural Health Services

The Multicultural Health Coalition is receiving funding from the Ontario government to assist it in establishing a health information service. The coalition will gather information on multicultural health services and how they could be improved, and will then develop a directory of available services.

Scott Task Force suggests cholesterol testing changes

The Task Force on the Use and Provision of Medical Services, headed by Graham Scott, has released recommendations that discourage the trend toward mass screening of the population for cholesterol levels. Instead, physicians are being encouraged to test only those people who are at high risk for elevated cholesterol levels, to request cheaper tests, and to prescribe anti-cholesterol drugs as a last resort. The task force that the changes could save tens of millions of dollars in health care costs.

Globe and Mail, April 8, 1989

Quebec MDs vehemently reject midwifery

Quebec physicians have reacted strongly to a announcement from Health Minister Therese Lavoie-Roux that she will introduce legislation to set up six pilot projects involving midwives. "You might as well make prostitution legal. More people are asking for prostitutes than midwives," said Augustin Roy, president of the 16,500-member Quebec Corporation of Physicians. Clement Richer, president of the Quebec Federation of General Practitioners, said that "It's like letting an apprentice pilot take charge of a Boeing 747 loaded with passengers." Helene Corneillier, president of the Quebec Alliance of Practicing Midwives, called the doctors' reaction "stupid and insulting....It really shows how little respect the medical establishment has for women." She said doctors' fears of midwifery are based on financial self-interest, and said they are "determined to maintain a monopoly of what they call medicine."

-Globe and Mail, May 11, 1989

MD punished for using midwife

A Montreal doctor has had his hospital privileges suspended for six months as punishment for letting a midwife deliver the baby of one of his patients. Dr. Clifford Blais was present during the birth, but let a midwife "catch" the baby, born February 21. The hospital said only a doctor could legally have performed the midwife's work.

-Globe and Mail, April 12, 1989

Meat inspections slashed

Canada's Agriculture Department has drastically reduced its border inspections of U.S. meat products as a result of the free trade agreement. Only about five per cent of U.S. meat products are now being inspected, compared with 100 per cent before free trade. Under the new system, Canadian inspectors are only make spots checks of meat. The National Farmers Union (NFU) has charged that the reductions prove that food quality standards are being lowered to conform to U.S. levels. Wayne Easter, president of the NFU, said that "this is especially critical with regard to chicken imports, because the production lines in many American poultry processing plants are so fast it is virtually impossible to inspect everything that goes through."

-Globe and Mail, March 2, 1989

Tobacco companies skirt ad ban

RJR-Macdonald and Imperial Tobacco have set up new subsidiaries to skirt the spirit of Ottawa's new restrictions on tobacco advertising. The Tobacco Products Control Act allows tobacco companies to sponsor sports and cultural events under corporate but not brand names. That posed a problem for RJR-Macdonald, whose Export brand represents about 80 per cent of the company's total sales. The circumvent the difficulty, it has set up a new subsidiary to be called Export 'A' Inc., which won't actually produce tobacco but will sponsor sports and cultural events. Imperial Tobacco has set up four similar subsidiaries: Players Ltd., DuMaurier Ltd., Matinee Ltd., and DuMaurier Council Ltd. Rothmans Benson & Hedges Inc. didn't have the same problem because its brands are already reflected in the company's corporate name.

-Toronto Star, April 14, 1989

'Alternative' Healers Fear Changes

The Natural Healers Association is expressing concern about the changes being proposed by the Ontario Health Legislation Review. The Association states that "should this proposed legislation become law, many holistic practitioners outside the medical field would be adversely affected and their treatments become unavailable." Their concern is especially with those provisions in the new legislation which would prevent unlicensed practitioners from performing diagnosis, performing procedures on tissue beyond the dermis, and prescribing or dispensing drugs.

Nurses boycott Toronto General

The Ontario Nurses Association is calling on nurses to boycott the Toronto General Hospital. The nurses charge that the hospital is failing to live up to the conditions of their contract. They say there have been delays in paying salary increases, failures to pay retroactive increases for parttimers, and preferential treatment for newly recruited nurses.

-Toronto Star, April 27, 1989, Globe and Mail, April 26, 1989

WHO turns down PLO

The World Health Organization has turned down a proposal to admit the Palestinian Liberation Organization as a member at this time. The WHO voted 80-49 against the Nicaraguan-sponsored proposal in a secret ballot. The proposal led the United States to threaten to withdraw funding from the WHO.