MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

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

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

"Warning: Poverty is hazardous to your health"

By Havi Echenberg
Executive Director, National
Anti-Poverty Organization

When Statistics Canada recently published data demonstrating that low-income Canadians died at a younger age than average, poor people were not surprised. Rather, they understood that the statisticians had finally "proved" what they already knew: **"Poverty reduces life expectancy."** Perhaps this warning notice should appear on every bill, cheque and notice issued by every government in Canada.

But poverty has more insidious impacts on living Canadians, most of which are evident from medical epidemiology. The impacts are also evident in social epidemiology; which is less precise although no less real.

When the National Anti-Poverty Organization reviewed literature from community-based organizations on health inequity and poverty, two broad categories of materials were included: those produced by agencies delivering community-based health services and those produced by grass-roots organizations focussing on the alleviation or elimination of poverty. Taken together, more than 200 documents from almost 100 organizations identified three clear and direct negative health effects of poverty: hunger/malnutrition, stress, and unsafe/unhealthy domestic and work environments.

Hunger and malnutrition are most dramatically evidenced by the stubborn persistence and continuing growth of charitable food distribution programs, including "sharing shelves" in school rooms, soup kitchens, and food pantries and foodbanks. Some Canadians were startled last year when the Canadian Association of Foodbanks published data showing that there are more charitable food programs than McDonald restaurants in Canada, and that 40 percent of the recipients of these programs were children. Poor Canadians did not share the surprise.

Nutritionists in Atlantic Canada have documented the impossibility of nutritious diets on incomes from social assistance. In Montreal and Edmonton, agencies are organizing co-operative food purchases and preparation for low-income Canadians. In Vancouver, Regina and St. John's, groups are working to find non-stigmatizing approaches to school food programs. And foodbanks in many cities are struggling with the moral dilemma of either legitimizing inadequate incomes and charitable food delivery or closing their doors in the face of people whose need for their food persists.

People on social assistance or inadequate wages, especially those trying to provide for children, describe the agony of having to choose between drug-free neighbourhoods and adequate diets, both essential to the health of their children. They tell of choosing between the school trip to the museum and milk in the last week of the month. It is clear that the issues is not one of ignorance of nutrition or inability to budget: the issue is that "Poverty increases risk of hunger and malnutrition."

Stress, too, is particularly pressing for parents, many of them sole-support parents, with inadequate incomes. Not only do they face all the same stress parenting brings regardless of income, but also they have fewer resources with which to alleviate or cope with the stress. Most Canadians buy their way out of stressful situations every day: taxis or dry cleaners can alleviate stress; a movie can help entertain children in miserable weather; dinner out or ordered in can save a hectic day. These solutions are simply not available to low-income people. For sole-support parents, the stress is exacerbated, by the threat of apprehension of their children by the state, if their incomes or, in fact, their health is judged to be inadequate to support their children.

The unsafe and unhealthy domestic and work environments were of grave concern to health services agencies and low-income activist groups. On the domestic front, low-income people usually have little choice as to housing. On the private market, affordable housing is usually run-down, often in industrial areas, and routinely located in communities without recreation space at close proximity. Rooming house fires are too frequent, and often result in injury or death to low-income tenants. In socially owned housing, design often neglected the need for play space for children, leaving them to play on elevators or on streets. As well, some of them have become attractive markets for small and large-scale dealers in non-prescription drugs.

In the workplace, low-income people are often working at unskilled or semi-skilled jobs, often without adequate training or appropriate safety measures and equipment. In the service sector, they are often doing hard physical work or are either standing or sitting for hours at a time. If the work is organized into shifts, public transit is often unavailable, and the neighbourhoods in which factories and offices are located are often unsafe outside traditional working hours.

Given these realities, it should not surprise anyone that the greatest progress against health inequity has been in areas where occasional or heroic medical intervention can effect significant results, and the least progress is evident in conditions exacerbated by stress, inadequate nutrition, and unhealthy or unsafe living and working environments.

This has particular significance for those in the medical field who support community-based health promotion. At the grass-roots level in low-income communities, health promotion efforts have two flaws. First, they're often based on promoting healthy choices; low-income people often define poverty as having no

choices. Second, health promotion campaigns often identify priorities based on medical, rather than social, epidemiology; smoking may be a health problem as defined by health care professionals, while it is a coping strategy for a sole-support mother living in poverty.

To promote health among low-income Canadians, then, health professionals will have to address the income issues, too. It is becoming increasingly evident that adequate incomes are not just good social policy; adequate incomes are also good health policy. Only by eliminating poverty can we promote health equity and health resources for all Canadians.

Medical Reform

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

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

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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.

Poverty – What's Being Done About It?

by Janet Mosher

In considering societal responses to poverty it is helpful to delineate two strategies – those whose intention it is to relieve against poverty and those whose intention it is to prevent or forestall the visitation of poverty. The vast majority of initiatives fall into the latter grouping, as will become clear below. It is also important to observe at the outset that almost invariably these initiatives are concerned with economic security – of course, other forms of security may flow from economic security but these effects are secondary only. I propose in the brief account that follows to describe, in a cursory way, some of the constituent elements of what may be described as our "income security system" and to consider the extent to which one may with conviction advance the claim that these initiatives, taken together, provide adequate protection against, and relief from, material deprivation.

Paid employment and a number of government initiatives related to it – the minimum wage, employment standards, labour market policy – fall within the "preventative" category of responses. Indeed, paid employment is probably the champion of preventative strategies. It has been, and continues to be, touted as the best strategy to avoid poverty. Indeed, I think it fair to say that as a society we represent (or perhaps more appropriately, "misrepresent") to our members that protection from material deprivation is each of our's for the asking if we would "get a job!" In other words, the claim is put much higher than a representation to be the best strategy. It's a claim that comes very close to being a guarantee. While it may well be true that of existing poverty avoidance options, paid employment is the best choice – at least for men; the more economically sound choice for many women, given the sex-segregated nature of the labour market, is to search out a male provider rather than paid employment – it falls far short of making good on its guarantee of protection from material deprivation. In fact, paid employment is less and less able to provide protection against material deprivation. A few recent trends will give some sense of this erosion and more generally, of the inadequacies of paid employment as a guard against poverty:

- The value of the minimum wage has declined by 22% since 1975. A full-time minimum wage earner can earn only 67% of the Statistics Canada urban poverty line for a single person.
- The vast majority of new jobs are in the service sector where jobs are low paying and dead end.
- The positive correlation between the number of weeks worked and a decline in household poverty has weakened in the past two decades. The number of working poor (49 weeks or full or part-time employment) families increased by 19% between 1973 and 1986. The increase for unattached working poor persons was 46%.
- Given the erosion of wages and inflation, among other things, families have been forced to intensify their wage earning by increasing the number of family members at work. The number of earners (two as opposed to one) has become increasingly important as a characteristic that distinguishes between poor and non-poor families. Indeed, many commentators have predicted that had women not entered the labour market at the rate which they have over the past two decades the rate of family poverty would be astronomically higher. Yet the very factors which make it economically necessary for families to intensify their labour market participation also result in a larger proportion of two-earner families experiencing poverty than two decades ago. We have also failed to adequately address the childcare implications raised by these economic realities.

The ability of paid employment to fend off the threat of poverty has historically been attributable not only to the wage but also to a number of initiatives intended, in their inception, to alleviate against the many contingencies of paid employment – unemployment insurance for those temporarily unemployed, workers' compensation for those injured in the workplace, and pension plans to enable employees to enjoy an old age free of the worry of the threat of poverty. But here too, we see an erosion in the protection afforded. Let us take unemployment insurance as an example. Unemployment benefits have been undergoing a trend of cutbacks

and tightening since the mid 1970s. The federal government's most recent attempt to curb UI spending, which is still before the Senate, would remove all government funding for UI (currently UI is financed through contributions from the government, employers and employees). Eligibility rules would be tightened, and both benefit levels and duration of benefits reduced. Experience suggests, and logic dictates, that if the proposed legislation is passed, more and more unemployed individuals will be obliged to look to the social assistance system where benefits are much lower than those associated with paid employment, and in fact, fall well below even the most stringent definition of poverty.

Not only is it the case that many of the jobs to be had in today's labour market provide little in the way of wages and less by way of opportunities for advancement, but the unemployment rate has altered little over the past decade. And while the rate has altered little, the actual number of unemployed persons has grown by 155,000 over the past decade. The government's promise in earlier years of full employment continues to be one of empty optimism. As D. Ross and R. Shillington note in *The Canadian Fact Book on Poverty*, "market income has done a dismal job of keeping poverty at bay."

Before turning to the second category of initiatives let me briefly note that there are hordes of other initiatives which in varying manners, and to varying degrees, could also be said to provide protection against poverty – the Family Allowance, Canada Pension Plan, Old Age Security, etc. While I do not have the time to review all of these nor the changes which have come about in the past decade or so, let me make two brief observations. First, a great many of these initiatives have been cut back in recent years, with the cutbacks often taking the form of a shift in eligibility requirements – from universal to needs- or means-tested. Second, it is also the case that the decline in the anti-poverty effect of paid employment would have been felt much more acutely in the absence of government spending on social programs.

With respect to the second category of initiatives – those designed to provide relief from poverty – the most significant program is social assistance, more commonly known as "welfare". In Ontario, social assistance (SA) is made up of two legislated benefit programs; general welfare assistance and family benefits. The original intention was that these programs would provide a safety net to maintain, at an adequate standard of living (a contentious concept), those unable to support themselves through paid employment or employment-related benefits.

While there are many definitions of "poverty" in Canada, the current rates paid under SA in Ontario fall well below even the most stringent definition. Actual numbers are revealing here; Statistics Canada places the "low-income cut-off" (poverty line) at $26,619. for a family of 4 living in a large urban centre in 1989. (I should add here that Statistics Canada poverty lines are not the most stringent.) By contrast, the same family would receive $12,516. in welfare benefits, less than half of the Statistics Canada poverty line. As the provincial government itself noted in its appointment of the Social Assistance Review Committee in 1986 to review the current SA system, SA has failed to meet its objective of ensuring an adequate standard of living for those unable to support themselves through paid employment. The government pointed to an obvious sign of this failure – the growing numbers of persons dependent upon food banks. (Nationwide it is estimated that 400,000 people receive emergency food each month. While children constitute only 26% of the population they account for 40% of those in line for emergency food.)

It is also clear that more and more people are coming to depend upon SA. Between 1969 and 1987 the SA caseload in Ontario increased by approximately 178%. The past 15 years has witnessed a dramatic increase in the number of children who are beneficiaries of SA. Currently, 4 of every 10 persons who rely on SA are children; 205,000 children in Ontario in 1987 representing 8-9% of Ontario's children. The fact that at least half of all poor children in Ontario are dependent upon SA gives some sense of the depth of the poverty which they experience.

While all of the above points to the conclusion that existing responses are failing to protect Canadians against poverty, a few further statistics will help seal that conclusion. While the rate of poverty (using Statistics Canada measures) in Canadian households has changed little since 1973, we have experienced a dramatic increase in the number of households living in poverty; an increase of 570,000 since 1973 to bring the total to 2.03 million in 1987. The face of poverty is also changing – unlike most of us, its face is becoming more youthful. A single person under the age of 25 years now has a one in three chance of living in poverty compared to one in five a decade ago. Both the rate and the number of children in poverty increased between 1973 and 1986. In 1986 the number of dependent poor children under 18 was well over 1.5 million. Young couples with children constitute a growing segment of the poor population. Poverty is also increasingly concentrated among single-parent families headed by women. Simultaneously there has been a decrease in the rate of poverty among the unattached elderly, although the rate continues to soar at unacceptably high levels, (for women over 65 the rate in 1988 was 54%).

There is limited data on one crucial aspect of poverty, its duration. The statistics cited above give only a snapshot picture of those who were poor in a given year. The limited data that does exist is generated by the SA system. This data indicates that the length of stay in the SA system varies depending upon family type, employability and a number of other factors. On average, employable singles receive welfare for 8 months, a single parent family 3-4 years. It is also the case that the average length of stay has increased significantly in the past decade. This data tells us only about the length of stay in the SA system. It sheds no light upon those who continue to experience poverty after leaving the SA system, nor upon the many poor persons who never enter the SA system.

In conclusion, it becomes apparent that existing responses are failing to protect Canadians against poverty. Let me end by briefly noting the social consequences of poverty. There is a great deal of research which points to the links between poverty and various debilitating behaviours and conditions. Illustrative of this research is the Ontario Child Health Study. Among its findings were that children from low-income families are almost twice as likely to suffer from a psychiatric disorder and have 1.5 times the frequency of chronic health problems than their non-poor contemporaries. As the Social Assistance Review Committee observed, these children are disadvantaged vis-a-vis non-poor children in terms of health, school performance, emotional adjustment and participation in extra-curricular activities. What kind of future is in store for them?

SARC Update

by Cathy Crowe

The Social Assistance Review Committee (SARC) was established to review social assistance in Ontario in order to better respond to the needs of the poor. SARC has 12 members, with Family Court Judge George Thompson as Chair. Its final 624 page report called "Transitions" was released in September 1988 and put poverty near the top of the political agenda.

More importantly, SARC has refuted the welfare bum image. Of those on social assistance, 41% are children, many of them under 12 years of age. Another 17.7% are persons with disabilities while 17.5% are sole support parents (mostly women), 6.1% have short-term medical problems and 8.3% are spouses of recipients or seniors. That leaves 9.5% of benefit recipients who are unemployed employables.

SARC made many recommendations to improve Welfare and Family Benefits laws. In May, 1989, the Minister of Community and Social Services announced improvements, all to be made within the current legislation in the General Welfare Assistance and Family Benefits Act. These new reforms have been given a price tag of $415 million for 1989-90. Other broader reforms such as the national child benefit, and disability insurance will need to come from the federal government.

What's happened to date, some highlights

STEP (Supports to Employment Programme), announced 5/89, implemented 10/89

The STEP programme (not to be confused with previous STEP programmes) is established to ensure social assistance recipients are better off working. It eliminates financial disincentives to return to work. For eg:

- removal of limit of hours a recipient is allowed to work before losing benefits (the 120 hour rule)
- provides a health benefits buffer by extending these benefits (drug card, dental care, eyeglasses, hearing aids, etc.) to *some* recipients who no longer qualify for social assistance cash benefits
- single parents can deduct some money for childcare expenses before the benefits are reduced

Continued on next page

The S.A.R.C. Report Card

SUBJECT	GRADE	COMMENTS
ADEQUACY (1) Income Levels (2) Benefits Provided	 FAIL FAIL	SARC appears to have moved towards adequate income levels in STAGE ONE. However, not only does this leave the recipient hopelessly below the poverty line, reductions in special and supplementary benefits would wipe out some or all of these gains.
HOUSING	FAIL	SARC makes no progress in housing whatsoever.
INDIVIDUAL RIGHTS (1) Right to Short Term Assistance	FAIL	We were hopeful when SARC made a recommendation to allow 16 and 17 years living on their own and homeless persons to collect welfare. Unfortunately, we cannot give SARC a passing grade in this area due to the introduction of "conditional entitlement". This action would allow social assistance administrators unlimited discretionary power to reduce or withhold welfare allowances for singles and heads of two parent families.
(2) Right to Long Term Assistance	FAIL	SARC also failed to preserve the right of single parents and the disabled to collect long term assistance.
EMPLOYMENT INITIATIVES	FAIL	SARC recommends the introduction of *Project Opportunity* as the main solution to employment initiatives. However this program falls short of a solution to facilitate reasonable employment because it does not provide resources such as bus passes, daycare, training, etc.. Further, SARC does not deal with pay equity.
ACCOUNTABILITY	FAIL	Immediate implementation of STAGE ONE without changes in statutes gives The Ministry of Community and Social Services for the first time the right to: 1) define the essential elements of social assistance programs 2) establish standards of delivery and 3) ensure that those standards are met without input from the Provincial Legislature "Conditional Entitlement", withdrawal of employment support resources from Vocational Rehabilitation Services (VRS) among other policy changes have already been implemented through regulations which are not consistent with the statutes. This process will destroy even the existing level of accountability.

OVERALL COMMENTS: SARC states objectives which are consistent with the communities' demands for humane progressive reform. However, the implementation of the recommendations will result in a serious regression in 1) adequacy, 2) rights, 3) employment initiatives and 4) accountability within the Social Welfare System as early as STAGE ONE.

Fairness and Equity Reforms, effective 10/89

Changes were also implemented to ensure more equity within the social assistance system. For eg:

- single men age 60-64 will now receive the same benefits as single women the same age
- funeral costs to be paid as a mandatory benefit rather than a special assistance which is discretionary
- a pilot project of direct deposit of cheques into recipients bank accounts has begun in Peterborough (many recipients must rely on cheque cashing operations that take a large percent of cheque)

Increased Childrens' Benefits

General Welfare Assistance childrens' rates have been equalized with Family Benefits childrens' rates. Benefits for children are also simplified to two age groups, birth to age 12, and 13 and over. Families with three or more children will receive an increase reflecting the real costs of a larger family.

Homeless Policy

This policy now expands its definition of dwelling place to include under a bridge, parking garage etc. to provide some assistance.

The SARC report card is not good.

CONCERNS

- Housing and childcare spots still remain severely inadequate
- Basic assistance rates are still inadequate. Families are still relying on food banks to supplement their diet. There is need for a 'market basket' approach to establish rates by looking at costs of basic needs
- need to improve medical benefits, for example, the Birth Control Pill is covered on the Ontario Drug Benefit Plan, however, IUDs, diaphragms, condoms are not.
- need for a *council of consumers* to oversee the implications of all social assistance reform
- the concept of *opportunity planning* as outlined in the SARC recommendations is flawed. Special training programmes may be put in place, but without the necessary supports and legislative intervention to increase the minimum wage, etc. the plan will not be workable
- need to establish a code of ethics for social assistance to ensure freedom from discrimination and to prevent the discretionary use of powers by welfare workers which may not be in their clients' best interests

Previous version of this article appeared in the RNAO tabloid

Facts and Fallacies – Resource Allocation

by H. Kirpalani & A. Oxman

John Iglehart has characterized national health insurance in Canada as a pressure cooker building up steam on a hot stove which is getting hotter (NEJM 1990; 322:5628). These pressures have lead to certain fallacies being propogated. Progressives should not be mislead by the noises emanating from the hot steam.

As pointed out by ourselves in the past, and recently by Allan Detsky et al. (CMAJ1990; 142:56572), it may be in the interest of the government, hospitals and physicians to have the facts remain unknown. In that way rhetoric and "orchestrated outrage" can be freely used without fear of being proven wrong.

In the absence of facts, a number of fallacies have emerged and tend to dominate the debate. In the hope of moving the debate forward, we will outline what we consider to be the key fallacies which are extant. Although a consensus has evolved at the last three semi-annual meetings regarding issues of resource allocation, a fair amount of confusion and discord remains. In order for the MRG to be heard, and to have a voice in shaping the future of health care in Ontario, it is essential for us to clarify and resolve our internal disagreements. Therefore, we would encourage those who disagree with us to openly express themselves in print in *Medical Reform*. Only then can we sort out facts, fallacies and philosophical viewpoints in debates over resource allocation. Controversy in our group should be viewed as a healthy route finding exercise.

Fallacy #1: An excessive amount of money is being spent on health care. There is a "crisis" in funding

The government would have us believe that health care costs are escalating out of control. The facts do not bear this out. Spending on health care has remained constant at about 8.5% of the GNP (NEJM 1989; 320:5717) and Ontario has, thus far, successfully contained hospital costs (CMAJ 1990; 142:56572).

Waiting lists for such procedures as hip replacement, cataract surgery, radiation therapy for cancer and coronary artery bypass surgery have been used to support arguments that the health care system is underfunded rather than over funded. At the same time, others have argued that billions of dollars are being wasted due to inefficiencies in the health care system (see, for example, Rachlis and Kushner, Second Opinion, Collins, Toronto, 1989; 30812).

While it is possible to speculate on the relative magnitudes of existing inefficiencies and unmet needs, the lack of data means that any estimates that are put forward must rely on assumptions and extrapolations of questionable validity. For example, although patients might prefer community based care over institutional care, the evidence that is available suggests that high quality community based care is not less expensive than hospital care. Also that preventive approaches by health service organizations and community health services are not in general significantly more applied than in fee-for-service settings. Abelson & Lomas, CMAJ 1990:142:575-581).

To take another example, although physicians consume a disproportionate share of the national income, other health care workers continue to be underpaid. While money might be saved by reducing the number of physicians and their income, it is not clear what the magnitude of these savings would be relative to the cost of increasing wages for other health care workers. However, it is worth noting that increases in hospital costs in Ontario in the 1980's are largely accounted for by hospital wage

increases (CMAJ 1990; 142:56572). It would be inconsistent with the MRG's third principle not to support these wage increases!

While it is possible to enumerate examples of both inefficiencies and shortages, such as these, it is not possible to say what the "right" amount that should be spent on health care is. This determination in essence is a political decision.

Until recently, the government was willing to act as the financier of health care without taking an active role in managing the health care system. However, a number of developments have led the government to reconsider its role in the health care system. Specifically, cutbacks in federal transfer payments, added pressure to contain health care costs and the threat of U.S. for-profit health care companies expanding into the Canadian market due to the free trade agreement (Ontario Medicine, June 4, 1990; 8), have induced the government to move towards managing the health care system, rather than just financing it.

These circumstances probably also underlie the shift from OHIP fees to an employer tax to fund OHIP. A likely result of this shift will be to engage private corporations in public debate in support of health care cost containment once the government begins to threaten to raise the employer tax to pay for increases in health are costs. In addition the effects of the general sales tax (GST) are clearly to shift even more tax burden onto "middle class" individuals – away from the corporations.

Correctly enough, physicians witnessing the government's move towards increased management of the health care system feel that their autonomy and their earning capacity are threatened. Obviously, the self interests of the government and organized medicine are in conflict under the evolving circumstances, and neither can be said to represent the interests of patients or society as a whole. Although the government is elected, examples such as the free trade agreement and the GST make it clear that the actions that governments take do not necessarily reflect the will of the people or their best interests!

In general, we would argue that the crisis in health care spending is neither one of overspending or underspending. In fact, the underlying problem is not in the health care system. It is in the capitalist system. Inefficiencies in health care reflect problems inherent in any capitalist economy. Indeed, while we would not want to trivialize the inefficiencies that exist in health care, it is fair to say that they pale by comparison with the waste, profiteering and inefficiencies that can be found in other sectors such as transportation, energy, construction and food industries.

Fallacy #2: Health care is not an important determinant of health.

This is the "sewer and drains" argument. Originally stated by Thomas Kc-Keown, this argument does have validity for especially developing countries. But it is Ludditism to ignore potential and actual benefit from new technologies.

This argument is, to a large extent, an overreaction to the dominant myth that health care is the only major determinant of health. But while health care is less important than other social, economic and environmental factors in explaining the health status of populations, health care is not unimportant. Effective treatments for a vast array of diseases such as asthma, diabetes orthopaedic problems and infectious diseases either prolong or improve the quality of life for millions of people. Effective preventive interventions such as immunizations also are of great benefit. While it is worthwhile to keep the relative contribution of health care in perspective, it is wrong to underestimate the contribution of effective health care to the quality of peoples lives. For progressives to do so plays into the hands of the cutters. It's also a ridiculous position to support in public, when patients can be paraded as in need of treatment, eg. children with acute leukemias. Both prevention and cure are important. This fallacy is the "turn the clock back" fallacy.

Fallacy #3: A choice must be made between health care services and other social welfare programs.

Although we live in a world in which resources are limited, our choices are not limited to choosing between health care and other social services, or between preventative and curative health care programs. These are artificial limitations that have been imposed on us and serve to protect the self interests of others; particularly those who benefit from excessive profits in all sectors of the economy. We should not be choosing between bone marrow transplants and immunizations or shelters for battered women. The national cake is larger than that and we should not be constrained to fights between legitimate demands of working people. We should be choosing between all relevant and desirable programs and profiteering, waste, inefficiencies and excesses in all sectors of the economy. This is the "squabble amongst yourself" argument.

Fallacy #4: Money saved from health care will be spent on other social welfare programs.

It is politically naive to assume that cutbacks in health care financing will result in increased spending on other social welfare programs. Who monitors such reallocations? To what extent have such reallocations occurred in the past? Given the past history of neglect for poverty, women's issues, natives' issues, etc., what is there to lead us to believe that this is likely to change during times of fiscal restraint? This is the ostrich "head in the sand" fallacy.

Fallacy #5: Rationing of effective health care is somehow inherently fair.

When effective therapies are denied it can be assumed that a private market will arise, and a two tier system will develop. This is, for example, what happened in the U.K. after chronic under expenditure on health care since 1945, and it is not hard to imagine the reemergence of private insurance in Canada as a response to increasing government constraints on health care spending. The inherent "fairness" of a two tier system lies in the acceptance that the poor do not have the right to expensive but effective therapy, whereas the rich do. While such a proposition is far less acceptable in Canada than in the U.S., there are those who argue that a two tier system already exists to some extent in Canada, or that it is inevitable in the face of limited resources, inequalities in wealth and access to health care in the U.S. Clearly, to the extent that these arguments are true, they suggest the need for an active role on the part of groups such as the MRG to defend universality (following from the first principle of the MRG). It is interesting that some of the MRG are to the right of some of the CMA. Dr. Eika Kluge (head of CMA) cites article 1401 and 1402 in the Free Trade Agreement and says: "There is no question whatsoever" that medicare will change under U.S. pressure towards a two-tiered system. This rationing argument justifies the rich having access to expensive and potentially beneficial forms of treatment whilst the poor are denied.

Fallacy #6: Decisions about the allocation of health care resources are so complex that they should be left to experts.

Acceptance of this proposition is tantamount to accepting that the allocation of health care resources cannot, by its very nature, be democratic. It also assumes that the incentives of the bureaucrats and "expert advisors" who are left to make decisions are consistent with the best interests of the public. It also results in decisions being made behind closed doors.

The fact that political incentives are often in conflict with the public's interests is evidenced by the extent to which government decisions are frequently not consistent with the best interests of the public. This fact also points to the need for greater democratic control of the allocation of health care expenditures, beyond voting every 4-5 years in general elections where many other issues contend for attention.

Fallacy #7: Health care decisions are somehow insulated from other political decisions.

Decisions regarding the allocation of health care resources are not made in a vacuum. In a political climate in which Thatcherism and Reaganism are accepted norms, where Michael Wilson can cheerfully proclaim himself a Thatcherite, decisions directed at improving the "efficiency" of the health care system must be viewed in a larger political context. In this context, improving "efficiency" can quickly become a means of cutting services. Sutherland argues that these "other" issues are irrelevant. To the contrary, they are the heart of the debate on the health care system.

Conclusions: The underlying crisis in health care is not one of over spending or under spending, it is a crisis in corporate profits. The major threat to the health care system is Thatcherism; i.e. the erosion of universality and the potential reemergence of private insurance and a two tier health care system.

Increased management of the health care system by the government is needed to control the budget while maintaining a publicly funded health care system with universal access and first dollar coverage. At the same time, in the current political climate, it is essential for groups such as the MRG to take an active role in ensuring that decisions about health care resource allocations are made openly, democratically, and in the interest of the public. Although the fight against Bill 94 was won, it is premature to conclude that the MRG no longer has a purpose (CMAJ 1990;142:13112).

The MRG Health Policy Menu

By Ralph Sutherland

The MRG cannot respond to every issue and headline that challenges health ministers and medical associations across Canada. In this situation it may be useful to create an "issues" menu. Such a menu might assist in choosing topics for analysis; it might also stimulate individuals to identify their areas of interest and comment on them.

The following list could be part of such a menu. Everyone will have additions. The categorizations are imprecise – many topics fit in many places. Items marked with an asterisk are those on which the MRG has a policy or has had recent discussions.

Control of Public Expenditures in Health Care

The capping of health care costs. (Capping is meant to imply an inflexible ceiling.)

The capping of expenditures on specific kinds of health services (hospitals, physicians, home care, etc).

The capping of the incomes of individual physicians.

Limiting billing numbers

Reductions in medical school enrollments

*Use of co-insurance (deterrent fees; extra billing; utilization fees)

Use of premiums (Alberta is to raise premiums until they represent 50% of medical costs).

Reduction of the range of insured services.

*Expansion of private sources of health care (the two-tier system)

Quality of Health Care

Termination of unsafe prescribing

Emphasis on cost-effectiveness research

Transfer of funds from items that are not cost-effective, or have low cost-effectiveness, to items of higher cost-effectiveness.

Resource Allocation

(Many of these questions would also appear in a category titled cost-effectiveness, value for money, priority setting)

Who should control it

What criteria should be used

The degree of emphasis on Quality of Life (or Healthfulness of Life) versus length of life

The conflicts between current benefits and future benefits

Health care versus other services also important to health

*Should funds be available for universal access to all health care treatments of confirmed efficacy?

The NDP proposal for a new medical school in Northern Ontario

Reduction of Caesarian section rates to 15% (as proposed by Elinor Caplan)

The high-tech investigation of persons with dementia

Control of practice patterns which are contrary to professional recommendations (fetal monitoring, caesarian sections, the periodic health examination guidelines of the CMA)

Physician Decision Making

Alteration of physician drug prescribing habits (mandatory sequency of similar drugs with markedly different costs, use of software to identify the most appropriate prescribing, provincial evaluation of physician prescribing)

Computer assisted diagnosis

More stringent limitations on the types of surgery for which a surgical assistant fee can be charged

Physician Payment and Incomes

(also see Cost Control)

General Practitioner/specialist comparisons)

WCB payment rates

Fee schedule negotiations

Fee schedule manipulations

Physician/Government Interaction

*The Health Disciplines Act

The licensing of foreign medical graduates

Consumer Control (Democratization of Health Care)

Primary Care (This list of topics will come from the Primary Care working group.)

Other Health Workers

The incomes of nurses

midwives

Research

Transfer of research activity from current areas of activity to research into cost-effectiveness and health care delivery.

Ethical Issues

Fetal rights

Assuring organ supply

When individuals want more or quicker service than can be provided by the publicly financed system.

Other

Federal cutbacks in transfer payments

Physician access to hospital privileges

The OMA request that the OHIP payment schedule apply immediately after relocation of a person from Quebec to Ontario

Compulsory membership in OMA

If physician and hospital services are to become available outside of the publicly funded programs what type of organization, payment, etc., are to be used in the second tier

Techniques for promoting redistribution of health care manpower (regional OHIP budgets, income differentials, a medical school in Northern Ontario.)

All matters on which the OMA, ONA (RNAO), C of P&S, etc. have a policy (breast screening, clinical protocols, etc)

All pronouncements by the Ontario MOH

Comprehensive Health Organizations

Boycotts of drugs or procedures that we think should not be done or should not be paid for with public money

How you responded to the questionnaire

A questionnaire was circulated to Medical Reform Group members through the newsletter this spring. The responses are given below. Where questions asked for a yes or no answer, the numbers of each response are given. As well, comments that were given are also given, and in some instances have been grouped according to the type of response. About 30 questionnaires had been received at the time of going to press. If you haven't sent yours in yet, please do so.

A number of themes can be seen as emerging from the questionnnaire responses.

One obvious one is continuing support for an active MRG. Members overwhelmingly indicated that they would want the MRG to continue, and that they would continue paying MRG dues, if all physicians are drafted into the Ontario Medical Association.

Responses indicate that making submissions to government and speaking to the public through the media are seen as the highest priorities for the MRG, with organizing and education within the medical professions and maong students, and joint activities with other groups also being seen as important.

Members clearly expressed interest in a wide range of issues; clearly the MRG is not seen as a one- or two-issue group. Members seemed to be comfortable with the idea of a variety of initiatives being taken as long as they fit within overall MRG policy.

On resource allocation, a range of positions are observable. A number of comments were along the lines of 'we have lots of common ground, let's get out there and take action'.

Many members said that they would like to see local meetings with guest speakers; als, not as many said that they would be willing to help organize such meetings or to join the Steering Committee. (Please... we still have vacancies.)

MRG Directions and Policy

1. What issues do you think the MRG should be concentrating on?

–Any health related issue which one or more member(s) is (are) willing to work on within MRG principles

–Be an alternative voice to the existing medical establishment

–We need to be a progressive voice of reform of physicians who disagree with OMA.

–A broad range of issues, including workplace health issues; pharmaceuticals industry; nursing; privatization and free trade; plus the usual resource allocation and models of health care delivery issues

–Political/public lobby re: health care system

–I don't have any energy for organizational work and if anything, I would be putting it into the Ontario Public Health Association. I don't know what role the MRG should continue to take, if any. As its members form other coalitions, are these not more important?

–The debate over a central focus for the MRG seems to be turning into something like the debate over the Canadian identity – a question that consumes so much time that people don't have the time or energy for anything else.

–Allocation of health care resources, medical ethics, rational application of scientific knowledge to clinical practice.

–1) Private health insurance; 2) primary care; 3) pharmaceuticals in CME & medical education: doctor issues like income oversupply

–Access

–Effective management of health care system within context of medicare principles

–Health care organization and economics (including the role and practices of pharmaceutical companies).

–Rational use of health care funding. Prevention of further "two-tier" system (access?)

–Resource Allocation issues; occupational health, AIDS, Mental Health, Poverty & Health, Native Health

–Resource allocation, future directions for medical care

–1) Resource allocation including health-affecting issues outside health care system; 2) mechanisms within the health care system for ensuring the most good is done with available money

–Setting the agenda for health care delivery and organization in the province

–Working on models of health care delivery

–Issues relating to the role of primary care in the organization of medicine in Ontario

–1) Primary health care models; 2) health care economics; 3) health care allocation; 4) abortion issue; 5) midwifery

–Payment systems (what is funded, what is not); Impact of federal budgetary restraints on health care; Delivery models

–1) Fighting "Rand formula" application by OMA; 2) continuing in resource allocation issues, taking positions on useless technology where evidence available

–Improvement of the Nurses' professional position and respect within the medical community

–The politics/sociology of scientific research, its profit motive, its competitive nature, its redundancy, poor quality, lack of co-ordination, or overall priority e.g. prevention, ethical realistic goals.

2. What forms of activity do you think we should be concentrating on?

Lobbying/Submissions to government: 15

Media: 11

Organizing/Education within medical profession: 5

Joint activities with other groups: 4

Policy Development/Development of clearly defined model: 3

Provide a sane and rational alternative to OMA & Min. of Health: 1

Gathering research information: 1

Education of public: 1

Health promotion: 1

Public meetings: 1

Comments:

–1st priority: Use media, public meetings, etc., to reach (a) public, (b) physicians, (c) medical students, (d) other health care workers. 2nd priority: limited government submissions. 3rd priority: Work with other groups, including U.S. pro-medicare physicians.

–Education of the public to utilize healthcare resources prudently and judiciously. Health Promotion. Physician education.

–Education through media & lobbying; submissions to government

–Government submissions where appropriate. Development of clearly defined model.

–Higher media profile

–I'd like to see us choose at most 3 or 4 issues, develop a strong analysis on them, advocate for policy changes very actively.

–I'm not sure which are most effective in increasing the health of population, which is after all the goal (isn't it?). I would think education within the profession and without

–Joint activities with other groups, e.g. progressive nurses groups, CHC organizations, Law Union, etc.

–Lobbying or submissions to government (most effective use of time).

–Lobbying, Submissions to government, joint activities with other groups, higher media profile, other health professions -- nursing/pharmacy, consumer associations

–Lobbying, submissions, gathering research information

–Media #1, then lobby government

–#1 media profile: this shapes public opinion/medical and government response. I feel government will only listen to us when we support their positions, therefore less useful.

–1) Policy Development; 2) Lobbying; 3) Media; 4) Work with other groups

–Probably higher media profile, with a view to maintaining our position as representatives of the people, but in white coats

–Providing a sane and rational alternative to the OMA and M. of Health for the public

3. What are your own particular areas of interest or expertise?

–AIDS/HIV

–Allocation of health care resource in manner that has an impact on health care and medical ethics

–Community Health

–Delivery models, technology/intervention assessment

–Development of progressive policies to address evolving situation

–Epidemiology and public health

–Global environmental, North-South, disarmament issues

–Health administration and planning

–Health Centres

–HSOs, CHOs, computerization

–I'm not sure I have many useful to our group: 1) good critical appraisal skills re: primary care issues, 2) a strong interventionist bias, 3) a sense of pleasure in taking on issues/causes that are related to individual patient problems

–medical ethics

–Medicine/Human Rights

–Midwifery

–Obstetrics, rural medicine

–Occupational health

–1) Primary health care models; 2) abortion issue

–As a retired layman (ex-Secondary School Principal) I have a participative interest in community organizations

–Varied interests

–Women's reproductive health

4. Do you agree with the Resource Allocation Group's proposals?

Yes: (50%)

No: (15%)

Partially/Qualified Yes: (15%)

No answer/Don't Know: (19%)

Comments:

–In general yes. I have concerns that we must also look at reallocation of resources within the health service industry

–No, since *most* therapy/medical interventions not "proven" (to be... what? useful? helpful? make people happy? live longer? etc., etc.) -- therefore leaves *all* medicine open to cuts. There are hidden moral and political dimensions to this

–Not as stated here, but otherwise yes

–Not without comparing "all proven useful health care interventions" with other methods of improving health

–Sort of. How can anyone support a system where we are pumping megabucks into health care with minor returns in overall health

–Very poorly worded questions. This is a perfect example of why public opinion polls are pre-judicial. Provide an alternative to the reader. If the alternative is a cap, say so!

–Yes, but so little is proven.

–Yes. But we need to translate them into 'sexy' public statements/positions on specific issues

5. Do you agree with the positions in Second Opinion?

Yes: (22%)

No: (4%)

Partially/Qualified Yes: (52%)

Haven't Read/No Answer/Don't Know: (22%)

Comments:

–Agree with a lot of it, but don't agree there would be much savings

–Agree with many but not all. There is a real danger of playing right into the hands of the neo-conservative agenda for cutting government-funded services and privatizing everything.

–Generally agree but feel savings in health care costs with rational use should be used within health care system.

–His book is inconsistent. I know what the resource allocation people want to hear but the question is poorly worded.

–I agree with much but not all.

–I agree with some of them, but I also agree with the sentiments expressed by Dr. Woolhandler in the April/90 newsletter.

–I do not agree with him and believe his positions are counter to the development of an effective universal system.

–My concerns with his views are that he can easily be used by conservatives

–Overall yes. However, Mike sees the health care consumer as an innocent victim of our system as opposed to part of the problem.

–Partly and partly. I disagree with the identification of cost containment as the central issue and unbalanced assessment of the role of health care.

6. Do you perceive a conflict between Michael Rachlis' positions and those of the Resource Allocation Working Group?

Yes: (39%)

No: (13%)

In some instances: (17%)

No Answer/Don't Know: (30%)

Comments:

–In some cases but much is a matter of emphasis.

–More in some peoples' minds than in reality.

–Not really. (Shocking to the group, I know!) (Question is too "in")

–Some! But we must concentrate our energies on areas of agreement which are substantial rather than spend energy in arguing with our allies for progressive health care reform (no one has all the answers)

–Yes, i.e. Michael would re-allocate current resources; RAG would increase funding to some existing programs as well as fund community-based services and other social spending

–Yes, mainly that support for that of the curve medicine is on is irresponsible when a) same money could do more good elsewhere & b) doctors should know how widely & indiscriminately expensive treatments are applied. Profession must take responsibility to limit use to the most needed situations and see that money spent in ways that improve health the most for all. I can see the problem with the Ministry of Health just "saving money", though, so the way any reallocation occurs is critical – central budget cutting almost certainly <u>not</u> the best way!

7. Other comments?

–The emphasis should be on unjust distribution of society's wealth and on importance of social/health spending. Inefficiencies should be pointed out, but this should not be the main message we give to the public.

–I believe in what I am doing in my work and find Rachlis' anti-doctor positions unhelpful.

–Maybe the steering committee should address itself to policy development at its monthly meetings (i.e. take up the work of the resource allocation group) and suspend or delegate as much other work as possible for the next year.

–Obviously, I'd like to see more concentration on the ethical dimensions of this debate. I'm distressed to see excessive concentration on cost/benefit analysis, etc.

–I am not an MD, are you interested in a non-MD health care constituency?

Your involvement in the MRG

10. Do you think the MRG's fees are a deterrent to membership?

Yes: (4%)

No: (64%)

Not sure: (32%)

Comments:

–To some potential members

–Not to me (from someone who said 'not sure')

11. Would you continue to pay MRG fees if all physicians were drafted into the Ontario Medical Association?

Yes: (92%)

Don't know: (8%)

Comments:

–Unthinkable!

–MRG would be all the more necessary

–I would mount a court challenge, consider giving up medicine on this issue alone

12. Are you presently a member of the OMA?

Yes: (35% of physician members)

No: (65% of physician members)

13. Do you think the MRG should remain primarily an organization of physicians and medical students?

Yes: (74%)

No: (19%)

Not sure: (7%)

Comments:

–for now

–add nurses

14. Are you interested in attending MRG local meetings on particular subjects with guest speakers?

Yes: 19

No: 4

Not sure: 1

Comments:

–If lunch hour format

–Without guest speakers (we do this in Ottawa)

15. What topics would you like to see meetings on?

–Both professional and more general applications (community-interest subjects)

–Changing role of medical practitioner, how to adapt to change, ethical decision making

–Discussion of issues the MRG is currently dealing with e.g. discussion and explanation of position

–Effects of privatization and free trade; attempts to bring medicare to U.S., comparison of U.S., British, Canadian systems (maybe Sweden?)

–Ethics of resource allocation

–health care costs; recruiting practitioners to alternative care

–Health care policy on subjects in #1

–Improve provision of health care and views from other health professionals

–Midwifery, health professions legislation review, anti-psychiatry organizing, community health centres

–Right now, I'm concentrating my limited time on working for CPPNW Board. Next year plan to come to more meetings.

–Same issues as provincial but also geared to medical students

–Strategies for change -- the general public has to come to agree that we need less smoking more than more CABs or they won't support shifting initiatives in that direction

–We might consider educationals on major legislative changes (e.g. CHOs, Independent Health Facilities) and try to attract outside physicians, students, politicians, and health workers

The Newsletter

18. Do you read the whole newsletter?

Yes: (52%)

No: (26%)

Most of it: (22%)

19. Do you show it to anyone else?

Yes: (23%)

No: (59%)

Sometimes: (18%)

20. What do you think the purpose of the newsletter should be:

–Analysis: 25

–Reporting on information about the MRG: 22

–Opinion: 22

–News: 20

–Reach out to people who are not members: 6 (4 No's)

Comments:

–Primarily it should aim at being a forum for discussion among progressive physicians and others interested in health care who share the same principles

–Keep interested MDs in touch

–I think it's very good

–I feel its present format meets my needs, i.e. contact with like thinking physicians as none in Thunder Bay

21. What do you think of the different sections of the newsletter? Would you like to see more, or less, of particular kinds of things:

–All good, as much as you can fit in

–All good. Clippings should be very selective.

–Current mix is good

–I think it's a great newsletter!

–It's all good. I think newsletter is excellent.

–Less Notices and Announcements

–Make germane analysis of health delivery issues.

–More discussion/debate, e.g. like Steffie Woolhandler's letter or Don Woodside's review with rebuttals, comments, exchange of letters, perhaps a la Brain and Behaviour where reviewers comments are published and letters to the editor-type section.

–More feature articles

–More feature articles, less newspaper clippings

–More features, more news briefs, others OK as is

–More features, reviews, news briefs; clippings and announcements as is

–More reviews

–A section on international medical situations might be useful

–Very dense type -- no fun

22. What kinds of articles would you like to see in future issues of the newsletter?

–Alternatives to traditional health care and views from other health professionals

–Broad base, as it is now, and important issues in provinces other than Ontario

–Continue as is but add international medical news

–How about expense of medical care in North with GPs doing much "consultant's work" vs. South

–how about some success stories

–I like the newsletter the way it now exists

–I think the newsletter has been very good recently

–Medicare and health care delivery systems in other countries; occupational health issues, privatization

–MRG info for MRG members

–patient

–Pharmaceutical companies in health education and research; independent health facilities; Reports on caps on physician income in Quebec & B.C.

–recent selection great

–Resource allocation debate

23. What do you think of the general meeting reports?

–About right: 74%

–Should be edited: 22%

–Too much coverage: 4%

Comments:

–Better if edited down, more pithy.

–I like to see the minutes, I actually read them

–I would prefer edited version of general meeting minutes, but is is **very** important to include such info.

–Minutes of meetings should be published – this is the only way that many people keep in touch with MRG activities

–More succinct summaries as opposed to the Magna Carta

–OK as is -- I think the inclusion of controversial discussion is always good to generate interest

–Should be edited and taken off front page

–The problem is with the meetings, not with the reporting

24. Who should be allowed to advertise in the newsletter?

MRG members: Yes: 20 No: 1

Non-profit or advocacy groups: Yes: 21 No: 1

Anyone who will pay: Yes: 10 No: 11

Comments:

–Advocacy groups shouldn't have to pay!

–Anything except pharmaceuticals

–For anyone who does not advocate something we would not agree with, i.e. against MRG principles or other commonly shared principles, e.g. Right-to-Life

–I like seeing ads from other groups

–More or less anyone who will pay, according to discretion of the editor

–No pharmaceuticals

–Sure, if it helps to defray costs but exclude drug companies and any groups that we don't wish to support

–with some exceptions, e.g. pharmaceuticals

–Yes for anyone with complete editorial freedom to reject ads!

–Yes, but I recognize the danger of inviting harmful influences

26. If you haven't written anything for the newsletter, why haven't you?

–Time: (7)

–I'm not a great writer. Too self-critical

–Lazy!

–Lousy writer

–Mainly due to chronic fatigue struggling with issues closer to individual patient care. Also I suppose I lack confidence in my ability to say anything worthwhile.

–Not asked

–Not my forte

–The usual reasons (time, energy, etc... middle age... yech!)

–Too damned lazy & disorganized

How could newsletter be distributed more widely:

–Are copies of the newsletter sent to all health sciences libraries in Ontario?

–As I do now i.e. read it, xerox it, and pass copies on

–Car delivery, hospital deliveries

–Colleagues at work

–Distribute at medical schools; advertise subscriptions

–Helping to brainstorm creative ways of doing this

–I belong to 4 or 5 different community groups. I could distribute it among those

–I could use contacts in clinics/hospitals to do mass distribution. Is this what we're talking about? Like NOW magazine?

–I'd give extra copies to colleagues who I feel would be interested.

–small # at a time to key people at med., nursing schools & libraries. I need 20-minute read at a time; this newsletter is daunting so I don't get too far.

–The newsletter in its present form is not a reasonable document for wide distribution

–Would like to hear proposal

28. Other comments about the newsletter?

–Good job

–Great

–I think it has improved a lot. Would appreciate more letters to the editor.

–It is really good!

–Its main purpose for me is to decrease my sense of isolation as I find it reassuring to hear similar positions from others

–More debate/discussion, more letters to the editor would be nice. Appearance and content both excellent

–My admiration and congratulations for keeping it going.

–Very good

30. Membership category of respondents

Physician: 23

Student/Intern: 1

Associate: 3

31. Type of work (e.g. private practice, community clinic, hospital-based, student, retired, etc.)

–Private practice: 8
–HSO: 2
–Community clinic: 3
–Hospital-based: 2
–Resident: 3
–Intern: 1
–University-based: 3
–Retiring from university-based position: 1
–Administrator: 1
–Pharmacist/ Community College Teacher: 1
–Maternity leave: 1
–Retired: 1

Medical Reform Group of Ontario General Meeting Minutes Saturday April 21, 1990

Don Woodside presented the Steering Committee report, a longer version of which appeared in the April newsletter. The report noted that the Steering Committee had been preoccupied with difficulties in responding to items in the news, and by a lack of energy on the Steering Committee.

Fred Freedman presented the proposed **budget** for the fiscal year October 1, 1990 to September 31, 1991. The budget assumes that membership levels will stay constant and that fees will remain the same. Based on this, a surplus is forecast for next year. As always, the budget is dependent on membership renewals and payments of Supporting Memberships.

There was a discussion of what happens to the MRG if all doctors are drafted into the **Ontario Medical Association**. Various people offered their speculations, but it was agreed that the best thing to do was to wait and see if this comes about, and on what terms.

The idea of organizing an **international conference** of progressive physicians was raised. There was interest in the idea, as well as scepticism about the costs. It was suggested that people who are interested in making this happen should get together to draft a proposal which the group can then consider.

The next item was the debate between Gord Guyatt and Ralph Sutherland.

Gord Guyatt began by listing what he saw as the things we value in the health care system. These included:

-High quality care

-Access: if I'm sick, I can get the care I need

-Equity

-Efficiency

Gord said that our system does a pretty good job on all these counts.

Gord presented the question: What is the greatest threat to the system? Gord's answer was that the greatest threat is what he called 'Thatcherism'.

He defined 'Thatcherism' as: (1) the contention that there is excess spending on social programs, that costs are out of control and must be contained; (2) individualism and privatization, leading to a two-tier system; (3) constraint, and the idea that any money for medicare has to come from other social programs.

According to Gord, the Ontario Medical Association is a poor counter to these trends. It complains about spending cuts, but is mainly concerned with its own positions and salaries, and is unwilling to look at inefficiencies in the system.

As services become strained, the middle class will start going outside the system. The MRG should challenge the dogma that any money for medicare has to come from other social welfare expenditures.

Gord said that there must be absolute support for funding of medical procedures that we know do more good than harm. We can still decry non-beneficial procedures. We can still demand evidence. We can still push the principle that the determinants of health are social and economic.

Ralph Sutherland said that the MRG needs to limit itself to the things that the other players in the health system are considering. This takes the question of how society spends its money off the agenda.

Ralph said that he does not support the statement that we should support all effective procedures. We have moved past the question of effectiveness to the question of **relative** cost effectiveness. We can't do everything that does the slightest bit of good.

According to Ralph, the discussion has been too health care related. We have to distinguish between health and health care. This becomes important if environmental factors, for instance, are shown to be more important to health than health care.

If the government puts money into health care, it will come from other social services. So the question has to be, what does more good, for example education or health care?

We already have a two-tier system; for example, alternative therapies are rapidly growing and are not covered by medicare. The real battle is over how we implement this. Thatcherism is a red herring. If social, occupational, and environmental factors are so important to health (as the MRG principles state) then this is where we should be spending money.

Debby Copes said that we have to think through our tactics in how we criticize particular things. For example, heart surgery. Capping expenditures on heart surgery will mean that some people who really need it don't get it, while others are getting it who don't really need it. Spending restraint as such as a focus doesn't address the issue of what is beneficial, and what priorities should be.

Fred Freedman said that there will always be competition for resources. You can't provide everything. So you have to make choices.

Fran Scott said that we can't always prove effectiveness. It is more important to prevent the need for a service than to provide it. What is proven effective is what the drug companies give money to prove effective.

Irv Brown said that 'effective' is a relative word because therapies change and new evidence comes in. Every therapy has a lot of people who support. He said that we have forgotten what it was like not to have access to health care. While social and other factors are important, people will break their legs no matter what kind of housing they have, and then they need access to care.

Mimi Divinsky said that the MRG's mandate is not to focus on how the government can best spend money. She raised the issue of better pay for nurses.

Don Woodside said that the MRG needs to focus on health care issues. We need agreement on equity and equal access. He raised the issue of whether we believe that everyone should have to have the same access to the health care system, e.g. organizations should not be allowed to buy private health insurance

inside or outside Canada. It can certainly be argued that if going out of the system is allowed, then it removes pressure to keep the system functioning well. If even the well-off have to use the system, they will insist that it be a good system.

Philip Berger said that corporate taxes won't go up: we have to work with the level of resources that are currently available. He said that much of the sense of crisis about the system is concocted by the Ontario Medical Association. He also raised the issue of accountability for how money is spent. His practice generates $1 million in costs to the health care system each year, and he is never asked to account for any of it. Meanwhile, community organizations with budgets of $50,000 have to account for every penny they spend.

Ralph Sutherland said that health care is important, but not as important as we think it is. If we want equal access to things that improve health then we want equal access to everything, because everything affects health.

Gord Guyatt that in Canada, we're all in the system, so the middle class is willing to pay more taxes to make the system better. So we have a better health care system and higher taxes than the U.S.

Susan Stock said that federal funding for health care is being cut back. We need to address that. She is concerned about focussing the group on getting rid of ineffective treatments. How do we ensure that the money saved goes to health?

Rosana Pellizzari said that it would be very poor strategy on our part to support any kind of capping. We need to say that all social services need funding.

Brian Gibson said that there will always be choices to be made. One is: what is in the system? Whatever it is, we want equitable access to it. But how do you decide what is in? There is a totally medical definition of what the system provides and therefore what you have access to.

Debby Copes said that doctors will say that everybody needs what I do. People need to be educated or they will believe what doctors say. People don't necessarily know where their self-interest lies.

Fred Freedman said that one of our goals should be to stimulate a rational debate in society at large. How about the MRG proposing a capped budget for health care?

Ralph Sutherland said that he supports capping, at the individual physician level, at the OHIP level, and at the Ministry level.

In the afternoon session, a number of news clippings which had been printed in the newsletter were listed and people split up into small groups to discuss them. The suggested clippings were:

-McMaster cuts 100 beds to meet deficit

-B.C. heart surgery patients go to U.S.

-OMA buys private medical insurance in U.S. for its members

-Two tier medicare

-Capping the medicare budget

-Walk-in clinics

-Review of costly medical technologies

-HSOs cut hospital costs

-Limiting tests for dementia

The topics chosen were Walk-in Clinics, OMA members may go south for treatment, Two-Tier Medicare, and Capping Expenditures for Physician Services. Four groups formed to look at the clippings, and also at comments on them prepared by Michael Rachlis, who was unable to attend the meeting.

The group looking at **Walk-In Clinics** (Bob James, Ford Guyatt, Debby Copes, Jim Sugiyama) said that it looked at them in the context of three questions: Why do they exist? What is wrong with them? and What can we do about them?

They exist because they meet a need, for example, your child is sick, and it's 4:30 -- where else can you take it? They generate unnecessary costs, because many people who go to a walk-in clinic then go to their own doctor anyway within a day or two, and the care may not be as good. Possible solutions are practitioners organizing into groups for after-hours care. Changes in or alternatives to the fee-for-service system are necessary, because it discourages doctors from giving phone advice and patient education. The group favoured eliminating bonus payments for this kind of service, and working for broader accessibility (geographic and temporal) to general practitioners. The meeting voted unanimously to accept this approach in principle.

The group looking at **OMA MDs buying U.S. health insurance** (Philip Berger, Mimi Divinsky, Bob Frankford, Don Woodside) wrote a press release and held a mock press conference. They stated that this is a propaganda ploy to undermine public confidence in the health care system. Private insurance undermines the political will to provide care for all. Any system will be fallible, but a publicly funded system of the kind we have is preferable, partly because it means public debate. This approach was also unanimously approved by the meeting.

The group looking at **two-tier medicare** (Haresh Kirpalani, Steve Hirshfeld, Miriam Garfinkle, Shawna Perlin) began by stating that health care is a right. There are disparities in the system, but we should be working toward decreasing them, not increasing them. Effective therapies should be medically insured. It pointed out that the proportion of the GNP devoted to health care has remained fairly constant. Their statement was approved 10 - 1.

The group looking at **capping expenditures on physician services** (Ralph Sutherland, Susan Stock, Brian Gibson, Walter Stuart) had trouble agreeing whether the news story they were discussing referred to caps on individual physician incomes or capping physician services as a whole. The group agreed that individual physician incomes should be capped, but was split about capping global incomes or capping health care expenditures generally. In the discussion, Miriam Garfinkle said that it is hard to talk about capping doctors' incomes without discussing how they are going to be paid. The group agreed that the disparity between MDs and non-MDs should be decreased. The idea of capping physician services as a whole was supported by 10 and opposed by 4. The idea of capping individual physician incomes was supported by 8 and opposed by 3.

It was agreed that the MRG could/should say that MDs generally are overpaid, and that the income distribution of MDs is very broad: some get paid far less than others, so any system of capping needs to take this into account.

A number of topics were suggested for the next general meeting and a straw vote was held:

Continued on next page ...

Democratization of health care system: 2 first round

Effectiveness: 2 first round, 2 second

Physician Reimbursement/Income - Supply & Services: 2 first round, 4 second

Primary Care: 5 first round, 7 second.

The meeting was adjourned at approximately 4:30 p.m.

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