MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

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

Volume 11, Number 2, April 1991

"The Third Principle" focus of MRG Spring General Meeting, April 27, 1991

"The Institutions of the Health System Must Be Changed"

The Spring General Meeting will be held Saturday, April 27 at the South Riverdale Community Health Centre, **1091 Queen St. East**, Toronto (just around the corner from the usual location at 126 Pape Avenue). The meeting will begin at 10:00 a.m. with brunch followed by the business meeting and discussion of a proposed resolution on Bill C-69. The actual wording of the resolution was not available as this newsletter went to press; however, the proposed resolution is based on the position taken in the article by Michael Rachlis on Bill C-69 in this issue. Registration for the meeting will be $25.

Beginning at 1:00 p.m. there will be a panel discussion of democratization in the health care system, focusing specifically on the MRG's third principle in relationship to hospitals and hospital workers. The panel will include Michael Hurley, President of the Ontario Council of Hospital Unions (CUPE), Janet Wright of the Ontario Public Service Employees Union (OPSEU), and Elsabeth Jensen, Immediate Past President of the Registered Nurses Association of Ontario (RNAO).

The Ontario Council of Hospital Unions represents over 20,000 support and clerical workers including medical technologists, clerical staff, registered nurse assistants, nurses' aids and allied help. OPSEU represents 100,000 employees of the provincial government, including hospital, ambulance, and social service workers. The RNAO is a professional organization representing registered nurses in Ontario. The Ontario Nurses' Association (ONA), which is a registered union, will not be represented on the panel.

The panel members will present their perspectives on the current situation with respect to decision-making in hospitals and their views on how the health care system should be changed to make it more democratic, particularly with respect to ensuring that health care workers have a direct say in decision-making and that the equally valuable contribution of all health care

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Occupational Health Group

An MRG Occupational Health Working Group was set up in November to develop MRG policy in occupational health that we could present to the Ministry of Labo;ur (and, if relevant, the Ministry of Health). The group has been meeting regularly since December and would welcome any other MRG members who are interested. For more information call Maritza Tennassee 416-572-4524 or Susan Stock 416-527-0149.

Democratizing the health care system: A proposal for discussion from the Resource Allocation Working Group

A DEMOCRATIC FORUM FOR DECISION-MAKING

Based on the general principles discussed at the last semi-annual meeting, the Resource Allocation Working Group has formulated a series of specific policy proposals. Democratic decision-making has been emphasized as a key element of many of these. The reasons why a democratic forum for resource allocation decision-making is needed are briefly summarized below as background to a proposed resolution that specifies the characteristics of a democratic forum that we believe the MRG should advocate.

THE NEED FOR A DEMOCRATIC FORUM

1. Inappropriate incentives and disincentives

Currently key decision-makers are likely to be motivated in ways that are in conflict with public interests. For example, politicians' electoral concerns often constrict their vision to a time frame that is limited by the next election and their financial alliances prompt them to focus on cost-containment rather than cost-effectiveness;

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Spring Meeting
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workers is recognized, as stated in the third principle:

The health care system should be structured in a manner in which the equally valuable contribution of all health care workers is 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.

Following a brief presentation by each of the panel members there will be an open and lively exchange of ideas and an opportunity to explore ways in which the MRG might put the third principle into practice, including prospects for working together with other organizations like the ones represented on the panel. Questions which we might want to address include:

How should the health care system be changed so as to allow health care workers and the public to have a direct say in resource allocation and how health care is provided?

Who should represent health care workers in determining health policy, who should represent the public, and how should they be held accountable?

How should pay equity be achieved?

Is de-institutionalization likely to make the health care system more or less democratic?

Is decentralization of health care planning likely to make the health care system more or less democratic?

Are elections feasible and desirable for hospital boards, district health councils or other health care institutions? If not, how should decision-makers in hospitals and elsewhere in the health care system be selected?

Does the current NDP government present health care workers with new opportunities for democratizing the health care system?

What, specifically, should the MRG be doing to put the third principle into practice?

Medical Reform

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

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

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

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

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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.

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bureaucrats' career concerns often motivate them to focus on internal political demands rather than health needs; and physicians' economic interests often come in conflict with public interests.

Although conflicting interests are, to some extent, inevitable in any system, a democratic forum in which decision-makers are directly elected to represent the health interests of the public is the best way of ensuring that the decision-makers' interests are congruent with the interests of the people they represent.

2. Inappropriate influence

Various interest groups, particularly affluent ones, have a disproportionate influence on decisions. Making decision-makers directly accountable to those whose health interests they are elected to represent can serve to reduce the potential for wielding financial resources to sway decisions.

3. Need for scrutiny

Many resource allocation decisions are now being made behind closed doors. An open democratic forum is essential if decision-makers are to be held accountable.

PROPOSED RESOLUTION

Given this background, it is proposed that:

Resource allocation decisions should be made in an open democratic forum which is characterized by:

1) open channels of communication for input from all health workers and the lay public in a representative fashion;
2) elections, similar in nature to education board elections, of grass roots representatives organised at places of work, health care institutions and at a neighbourhood level;
3) elections among the grass roots representatives of centralized review boards with the following mandate: to set priorities for health expenditures, to ensure traceability of redistributed funds, to critically review government policies regarding resource allocations, and to meet with special interest groups to hear their views and adjudicate between differing points of view;
4) empowerment of the review boards with the right to veto Ministry of Health decisions;
5) all decisions made openly and background information made readily accessible to all interested parties;
6) all elected representatives subject to removal by the right of instant recall by their constituency.

Summary of Presentation to the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women

By Michael Rachlis
January 22, 1991

I am honoured to have been asked to appear before this committee and I sincerely hope the members will not think ill of my presentation because I have not strictly kept to the agenda.

The Committee's Agenda is Irrelevant

The Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women has chosen to study the funding of the health care system. In particular, the committee has chosen to investigate the impact of the aging population on the health care system, the problems with accessibility of health services for certain Canadians, and the human resources for health care. I suggest that it is irrelevant for the committee to be discussing these issues while the Federal Government is denying itself a role in Canada's Health Care system. In fact, the Committee's agenda is worse than irrelevant. The Committee is guilty of the most grievous negligence by refusing to act while the Federal Government allows medicare to slowly die.

Why is Medicare in Trouble

Medicare has many problems but Canadians have created a health care system that is the envy of most of the rest of the world. Canada has achieved universal coverage for hospital and medical care without charging users at the time of service. We spend much less of our gross national product on health care than the United States and roughly the same portion as the other wealthy industrialized nations.

On the negative side, we have a system tilted towards care within institutions provided by physicians and we have not carefully evaluated most interventions for their effectiveness or efficiency. We also know that hospital and physicians services are much less important for the health status of Canadians than the public currently believes. The Committee has heard many learned witnesses discuss these issues with little disagreement amongst them. However, the system of public financing for hospital and physicians care without user charges is fundamentally sound and the previous witnesses have also made this point.

Medicare is in trouble because some groups and some provincial governments have never accepted the basic principles of Medicare and the present Federal Government refuses to protect what has become Canada's best-loved social program. It may be hard for the members of this committee to believe that a Federal Government which continues to publicly profess its interest in Medicare (and when in opposition voted unanimously for the Canada Health Act) could actually be destroying it. Some brief history may assist the members in understanding the subtlety of this issue.

A Brief History of Medicare

Canada's health care system was in its infancy when the Saskatchewan Government of Tommy Douglas implemented public hospital insurance in 1946. The program was a great success both in human and financial terms. This resulted in some other provinces implementing similar programs. The Federal Government was somewhat concerned about entering into this area because the British North America Act had given the provinces the responsibility for health care. However, eventually, it was concluded that the Federal Government could use their fiscal power to *influence* the Provinces. In 1957 the Federal Government passed the Hospital Insurance and Diagnostic Services Act. This Act allowed the Federal Government to pay for half the costs of hospital care if the provinces implemented a hospital insurance plan which met certain conditions.

Saskatchewan again led the way with public medical insurance, implementing such a plan in 1962. Justice Emmett Hall's Royal Commission recommended a Federal medical insurance program in 1964 and the Medical Care Act was passed in 1966. Like the Hospital Insurance Act, with the Medical Care Act, the Federal Government agreed to pay one-half the costs of medical care if the provinces established public medical insurance programs with certain conditions:

1. The plan was to be administered on a non-profit basis by a public authority appointed or designated by the provincial government.
2. The plan was to provide for a) the furnishing of insured services upon uniform terms and conditions, b)

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Health Care Reform: Issues for the 1990s

The Medical Reform Group is to be commended for its choice of principles. The values inherent in these principles are in harmony with the health care reform policy that has guided the activities of the Registered Nurses Association of Ontario since the 1970s.

As the last decade of the twentieth century dawns, the restructuring of the health care system is possible.

It is now possible to see a system in which various professional groups work with each other and the public as partners. The legislative institutions have the capacity to change the fundamental values related to health and health care. The very culture of the health care system could be quite different by the turn of the century.

At this time, when the ideals are within reach, it is essential to exert the final effort needed to ensure the full step forward. Many vested interests still fear the coming change. Helping them along will be important. Keeping the movement going in the face of such resistance is also important. Building bridges to supportive partners is an essential strategy for managing change, and marketing the vision is key. Although small in number, the MRG has a key role to play in shaping a preferred future for the health of Ontario.

Elsabeth Jensen, R.N., B.A., B.Sc.N., SRS

Immediate Past President, Registered Nurses Association of Ontario

Elsabeth Jensen will be a speaker at the Medical Reform Group's Spring General Meeting, April 27, 1991.

Committee on Health & Welfare... Continued from Page Three

reasonable compensation of doctors, and c) reasonable access to insured services.

3. The plan was to provide for universality of coverage.
4. The plan was to be portable from province to province.
5. The plan was to be comprehensive in its coverage.

Despite the loud protests of some provinces (notably Ontario) all provinces had joined the program by 1971 because they could not resist the Federal money. In other words, the Federal strategy of cost-sharing had been successful in ensuring national standards for health insurance. Even when some provinces were in philosophical and political disagreement with the Federal position they were coerced to join the program by the Federal money.

Despite Medicare's success, problems developed in the 1970s. The Federal Government simply paid the bills as they came through and could not plan its expenditures. The poorer provinces couldn't spend as much as the wealthier provinces and therefore, were practically less able to get Federal money. The Federal money was only provided for hospital or medical care but there was substantial evidence that it was often more appropriate to provide care in the community or with nurses and other non-physician health personnel.

As a result, the Federal government in 1977, after consultation with the provinces passed the Established Programs Financing Act (EPF). Under EPF the Federal Government converted its payments to the provinces to cash transfers and tax points. The Federal Government decreased its personal income tax rate by 13.5% and its corporate rate by 1%. This allowed the provinces to increase their tax rates by these amounts without increasing the overall tax bill.

The Federal government agreed to maintain their overall proportion of the funding of hospitals and physicians care through a combination of the transferred tax points and the cash transfers. The overall Federal contribution was calculated as a sum of the revenues from the tax points transferred and the cash transfers and was to grow according to a formula based on growth of the gross national product and population.

In 1984, the Trudeau Government passed the Canada Health Act which subsumed the Hospital Insurance and Diagnostic Services Act and Medical Care Act. Additionally, it provided for specific penalties for Provinces which allowed hospitals or physicians to levy user charges. The Canada Health Act allowed the Federal government to reduce its cash transfers under EPF by the amount of user charges levied in a province. The Act allowed the Federal Government to apply more general penalties if a province were assessed as breaching one of the other national standards.

The Trudeau government made the first change in the EPF funding formula when they subjected the federal contribution for post-secondary education to the same temporary growth restrictions as other programs in the '6 & 5' restraint program in 1983-84 and 1984-85.

Since its election the present Mulroney Government has made two structural changes in the formula.

- Bill C-96 was passed in 1986. It decreased the growth in the Federal contribution under EPF to *2% less than the growth in GNP.*
- Bill C-69 was passed by the House of Commons in June, 1990 and is now before the Senate. It would freeze the Federal contribution for 1990-91 and 1991-92 and then would decrease the growth in the Federal contribution under EPF to *3% less than the growth in GNP.*

The tax points have grown in value commensurate with growth in the economy as a whole, *but* since 1986, the value of the Federal contribution has diminished compared to the growth in the GNP. Because the Federal Government calculates its cash transfers under EPF by subtracting the value of the tax points from its estimated contribution under EPF, the cash transfers have been diminishing in real value since 1986. *If Bill C-69 is passed by the Senate, the value of the cash transfers will diminish much more rapidly. Within 7 to 10 years, THERE WILL BE NO CASH TRANSFERRED UNDER EPF.*

The End of Cash Transfers under EPF will kill Medicare

When the Federal Government ceases to transfer cash to the provinces under EPF it will no longer be able to enforce the national standards in the Canada Health Act. The only method to enforce these national standards is for the Federal Government to cut its cash TRANSFERRED to an offending province under EPF. *Despite some public statements by representatives of the Federal Government, provinces will then be free to institute user charges and even allow private insurance for basic hospital and physicians care. There is no legal provision for the Federal Government to cut back its equalization payments or recall the tax points TRANSFERRED in 1977 to enforce the national standards in the Canada Health Act.*

Canadians can already see the demise of medicare on the horizon. The Finance Minister of British Columbia, the Hon. Mel Couvelier has led a move by the provinces to gain complete control of medicare earlier. Mr. Couvelier has suggested the Federal Government should immediately eliminate its cash transfers under EPF by converting these transfers to tax points. In making a case for this so-called "disentanglement", Mr. Couvelier has specifically questioned the principles of universality and national standards.

In December, 1990, the Quebec Minister of Health and Social Affairs Hon. Marc-Yvan Cote recommended a broad sweep of health care reforms. While most of these reforms are quite laudable, M. Cote's plans included a $5 user charge for 'frivolous' use of an emergency department. The Hon. Gil Remillard, Quebec's Minister of intergovernmental affairs was quoted as saying that the Federal Government would cease transferring cash to Quebec under EPF by 1997 and therefore, the Canada Health Act would soon be meaningless.

National Standards for Medicare are Crucial for Efficient Health Care and National Unity

Mr. Couvelier and M. Remillard have made it clear that they disagree with the national standards for universality and accessibility. There can be no question that certain provinces will seize upon the elimination of the EPF cash transfers to dismantle their medicare programs. One must remember that several provinces would never have implemented medicare without

Federal coercion. This will be a disaster for residents of those provinces and will be a further nail in Canada's coffin.

Non-profit, public administration ensures that overhead costs of health care are kept low. Money is spent on patient care not on a costly infrastructure of actuaries and premium collection. The standard of comprehensiveness ensures that coverage is not arbitrarily deleted for certain illnesses or procedures. The standard of universality ensures that coverage is not deleted for certain persons. The standard of portability ensures that Canadians can receive care under similar conditions in different parts of the country. The standard of accessibility ensures that provinces which allow hospitals or physicians to levy user charges are specifically penalized. It also suggests mechanisms for achieving reasonable compensation for physicians and dentists.

Canadians, particularly English Canadians have defined themselves as not being Americans. We consider that Medicare is living proof that Canadians are more socially concerned than our neighbours to the South. With the gradual elimination of other national institutions, Medicare stands as a glowing symbol of our national identity. Can any of the members of the Committee imagine a Canada where people are denied health care for financial reasons?

The Committee Should Petition the Senate to amend Bill C-69

This Federal Government is in the process of dismantling Medicare and has disavowed for itself any meaningful role in this country's health care system. If the members of the Standing Committee on Health and Welfare truly wish to study Canada's health care system they first should ensure that Canadians will still have a national Medicare program in the 21st century. *Therefore, if the members of this committee really want to preserve Medicare, I respectfully recommend that you discontinue your hearings and spend all your energies convincing the Senate to amend Bill C-69 so that the formula for the Federal contribution for EPF is made the same as it was under the original Established Programs Financing Act of 1977.*

After the Federal Government has reasserted a role for itself in Canada's health care system, I would be more than happy to address the other issues on the Committee's agenda. Thank you for your attention.

Note: Bill C-69 was passed by the Senate in February 1991. In that same month, the 1991 federal budget was released which continues the freeze on the growth of the federal contribution under EPS for three further years.

A resolution on Bill C-69 based on the analysis in this article will be presented for possible adoption as MRG policy at the Spring General Meeting. The actual wording of the proposed resolution was not available as this

Steering Committee Activities

The following summary of MRG Steering Committee activities is taken from the minutes of the period covering October 1990 to April 1991. An oral Steering Committee report will be presented at the April 27 General Meeting.

NDP government

A special evening membership meeting was held in late November to discuss what issues the MRG should be advancing in its approach to the new NDP government. Among the issues identified as priorities from the MRG's point of view were:

- Reducing inequalities between physicians and other health care workers
- High quality care in the most efficient way possible, rather than cost containment. Don't define the issue as a choice between health care and other social programs
- Democratization
- The dangers of privatization and extra billing
- More co-operation between the parts of the system

Health Insurance Numbers

Philip Berger raised concerns about the implementation of the new health insurance numbers. Many people who have a new number yet, especially poor people, street people: people who frequently don't do anything requiring paperwork. The Ministry of Health's plans were to stop paying physicians for care provided to anyone without a number after January 1, effectively either depriving such people of health care or forcing physicians who see them to do so without payment. These concerns were brought to the Ministry of Health.

Meeting with the Minister

Three MRG Steering Committee members (Rosana Pellizzari, John Frank, and Gord Guyatt) met with the Minister of Health, Evelyn Gigantes, on December 6. The points raised by the MRG representatives at the meeting included the importance of maintaining and improving the quality of medical care while improving efficiency; concerns over continuing 'covert' extra-billing, especially in certain specialities; and concerns about the large numbers of disadvantaged people not yet enrolled in the new Ministry of Health health card system. As one result of the meeting, a list of MRG members with expertise and experience in various issues was prepared and forwarded to the Minister's office.

New initiatives

An Occupational Health Working Group has been meeting regularly.

Several MRG members have been looking at the possibility of forming a working group on native health issues.

Gulf Crisis: At its January 10 meeting, the Steering Committee decided to send a letter to Prime Minister Brian Mulroney expressing its concern over the apparently imminent outbreak of war in the Persian Gulf and urging that every effort be made to find a peaceful solution to the crisis.

Murray Enkin suggested taking some new initiatives to attract new members to the MRG. Specifically, he suggested a 'chain letter' approach whereby each MRG member would be asked to send out letters to 3 to 5 other physicians s/he knows, inviting them to join the MRG.

A new membership category was created for Residents. The fee for this category will be $50.

Contacts with other organizations

Frances Kilbertus, the MRG's rep-

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Steering Committee Report...
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Canadian Health Coalition's recent activities, which have placed special emphasis on Bill C-69, the federal legislation which is seen as presenting a serious threat to medicare and other social programs.

MRG members, including Gord Guyatt, Rosana Pellizzari, and Andy Oxman, made a number of trips south of the border to speak to American audiences interested in knowing more about the Canadian health care system.

Michael Hurley, the President of the Ontario Council of Hospital Unions (CUPE), was invited to the February 7 Steering Committee meeting. His union represents about 20,000 hospital workers, including maintenance, clerical, laundry, and housekeeping workers, nursing assistants, some nurses, and others. The union is keenly interested in democratization of the health care system and is concerned about 'de-institutionalization', which they see as being primarily as a cynical move to cuts costs, covered by the rhetoric of community care, resulting in the 'dumping' of patients into settings where adequate resources and care are not available. Hospital funding decisions are another matter of key concern to the union.

Mimi Divinsky, with help from Nikki Colodny and Debby Copes, prepared a talk on abortion issues which she delivered at a meeting of the NDP left caucus. The points she stressed in her presentation included free-standing clinics, the question of declaring the federal abortion law unenforceable, paying for women to go to the nearest clinic, setting up an 800 number for abortion referrals. Also suggested was asking the government to look again at the recommendations contained in Marion Powell's report of three years ago.

The Steering Committee sent a letter to the Senate Committee looking at the abortion legislation, stating the MRG's position against the proposed legislation, which eventually died in the Senate.

Payment of Physicians

By Michael Rachlis

Executive Summary of a Brief Presented to the City of Toronto Board of Health

On January 16, 1991, the Ontario Government began negotiations with the Ontario Medical Association on increases to the Ontario Health Insurance Plan (OHIP) fee schedule. There have been no increases negotiated yet for 1989-90 or 1990-91. There are a number of issues in these negotiations which should concern the Board of Health and the Public Health community. This report summarizes the key issues and makes recommendations to the Board.

Problems with the Current Negotiation Process

1. There is no fiscal control

Ontario doctors have increased their portion of the Provincial budget by over 60% (from 6.0% to almost 10%). If doctors received the same proportion of the Ontario budget this year as they did 13 years ago, there would be $1.6 billion available for other purposes.

Ontario per capita expenditures on doctors' services are far and away the highest in the country. According to Health and Welfare Canada, in 1989 - 90, Ontario spent $441 per capita on doctors' services while British Columbia spent $350, Alberta $288, and the other provinces spent around $200 to $250. If Ontario only spent the same amount per capita on doctors' services as BC there would be almost $1 Billion dollars available for other purposes.

Part of the increase in payments to doctors in the past decade is due to large increases in the OHIP fee schedule in the mid-1980s, but there was only a 1.75% increase in 1988 - 89 with no increase since. Part of the higher costs are due to the increased utilization of doctors' services, particularly after the ban on extra billing in 1986. In fact, the costs of physicians services increased by over 9% in 1989-90 **despite the fact that no increase has yet been negotiated in the OHIP fee schedule.**

Part of the higher costs are due to the increase in the number of doctors registered with OHIP. The number of doctors per capita has increased by 25% in the past 15 years.

The OMA has claimed that the cost increase is due to patients demanding more services, an aging population, and the development of sophisticated new treatments. However, the evidence does not support these arguments.

Although patients usually decide to initially contact a doctor, the doctor makes the decision about future visits and treatments. For example, some doctors see patients with high blood pressure once a month even though they could be seen once or twice per year.

The increased costs due to the aging of the population alone is less than 0.5% per year.

Most medical diagnostic tests and treatments have never been evaluated for their effectiveness. One brain operation was performed for twenty years before it was evaluated and found useless.

2. Better doctors are penalized for practicing better medicine and this frustrates the Province's priorities for medical care

Despite the massive increase in costs for doctors services, many individual physicians have not done well. Most of the money has gone to the new doctors registered with OHIP or to doctors who have increased their patient volume. Family doctors who only see 4 or 5 patients per hour **and who have found it unconscionable to increase their volume**, have seen their incomes fall against inflation the past three years. Furthermore, doctors who see patients with complicated problems (e.g.. AIDS, chronic mental illness, the homebound elderly and disabled) have been especially penalized. Family doctors can make an excellent living working for walk-in clinics or housecall services seeing people with minor illness who should never see a doctor at all. Or, they can see healthy people in their offices from 9 to 5, not take any night call (booking off to an answering service after hours), and refer patients with any potentially serious problem to a specialist. Doctors are penalized financially for:

- seeing patients who have serious ill-

nesses and really need medical care,

- leaving time in their daily schedules to see patients on an urgent basis,
- managing complicated patients themselves instead of referring them to specialists,
- making housecalls to enable elderly and disabled persons to live independently and to allow persons with terminal illness to die at home, and
- taking call in the evening and on weekends.

Furthermore, the OHIP fee schedule is the same throughout the Province despite the fact there is a massive surplus of physicians in Southern Ontario and shortages in many northern and remote communities.

3. Negotiations with physicians are not like other labour negotiation

In contrast to ordinary labour-management relationships, the Government does not control the total costs of physicians' services because it doesn't control the number of doctors or the number of services doctors provide. Also, the Ontario Medical Association has historically controlled the distribution of dollars within the profession. The OHIP fee schedule preferentially rewards doctors who perform procedures (insert needles, perform surgery, et cetera). Various provincial reports in the past four years have recommended the improvement of community-based primary care and the further development of alternatives to the fee-for-service method of payment. If Government were truly acting the part of the employer it would raise the payment for services it wanted and reduce payments for those services it felt were being provided too frequently. The OMA wants binding arbitration to settle disputes and the Rand formula which would provide compulsory dues payment by doctors who were not members of the OMA. If the OMA won these points they would gain the rights of a trade union without the Government gaining the rights of the employer to set hours and conditions of work.

Analysis of the physician payment issue

The present system of open-ended, fee-for-service payments to physicians has allowed expenditures on physicians services to increase to nearly one-tenth of the overall Provincial budget. At the same time there are still major problems with access to physicians services by some types of patients and in certain communities. Furthermore, better doctors practicing better medicine are often paid less than those doctors who practice low-quality "revolving door" medicine.

A continuation of the present system is contrary to the first Provincial health goal elaborated by the Premier's Council on Health Strategy and the 33rd recommendation of Healthy Toronto 2000 both of which refer to shifting the emphasis of the health care system to health promotion.

Recommendations

1. The Provincial Government should implement an overall cap on expenditures for physicians' services. Otherwise, the sharply increasing payments to doctors will compromise the Government's ability to redirect funds to public health and health promotion, including social assistance reform, housing, and food programs.
2. Within an overall cap on payments to physicians, the Provincial Government should establish a joint task force with the Ontario Medical Association to re-design the method of paying for physicians services so that appropriate incentives are instituted to achieve Provincial health goals as articulated by the Premier's Council On Health Strategy.

   The payment system for physicians should reward doctors who practice high-quality medicine and discourage so-called "revolving door" medical practice.
3. The Board of Health should ask the Provincial Government to make a representation to the task force described in recommendation #2. Furthermore, the Board of Health should ask the Provincial Government to educate the public about the issues involved in the negotiations between the Provincial Government and the Ontario Medical Association.

It is clear from other provinces that medical associations will attempt to convince the public that a capping of physicians' billings would restrict access to medical care. This assertion is not true and furthermore, if physician billings are not capped (with redistribution), there will not be money available for other areas of social policy which do have a major impact on the populations' access to health.

About Chain letters, memberships, and surveys

Enclosed with this newsletter you will find several copies of a letter intended for prospective new members of the Medical Reform Group. We (the Steering Committee) are asking every member to consider who of their acquaintances and colleagues they think might support the goals and principles of the MRG, and then to send them a copy of the enclosed letter. (Additional copies are available, and additional information, such as newsletters, policy booklets, or membership brochures, can be sent out on request.

The purpose of this initiative is to attempt to increase the number of members of the MRG. We have made almost no systematic efforts in recent years to attract new members, yet we believe that the principles of the MRG are becoming more relevant than ever as the health care system confronts the dangers and opportunities in this critical period in Canada's history.

The Steering Committee hopes that the enclosed 'chain letters' will function as a way of making ourselves known to prospective new members in a way that our budget can handle.

Please let us know if you require more letters or other printed information, or if you have other ideas for making the MRG and its principles better known.

The Steering Committee would like to thank **Jim Sugiyama**, our membership co-ordinator, for drafting the letter.

Have you renewed?

Speaking of memberships... there are still some members who haven't sent in their membership renewals yet. Please drop it in the mail soon!

Surveys

The last issue of *Medical Reform* contained a survey of members' experience and expertise whose purpose is to generate a list of knowledgeable individuals available to be consulted by the Ministry of Health. If you haven't sent in your survey form, and you've been meaning to do so, please send it in soon so that the list can be finalized.

Gulf statement called undemocratic

To: MRG Steering Committee

Re: Letter to Mulroney re: Gulf War

The letter that follows outlines my views on the Gulf situation. Aside from that, however, is the process the MRG Steering Committee went through to ensure that the MRG was properly represented by the letter.

The MRG has no policy in any remote way relating to war or aggression that I can find. As a result, there is no precedent for a policy statement on the Gulf. I realize that in a crisis situation the Steering Committee must occasionally act. In the past this has always been preceded by a telephone poll of some members. I understand that this did not occur.

What I see is a public letter under MRG letterhead signed by 5 members of the steering committee (is that a quorum even?), with no policy precedent, and without an attempt to assess membership views on the subject.

Even if, as I suspect, I am in a minority position, democracy and open discussion within the MRG has not been served.

Fred Freedman

Meet aggression with force

22 January, 1991

I must respond to the letter sent to Brian Mulroney regarding the Gulf situation. I know my comments will be unpopular with some, but I can't simply accept the knee-jerk reaction to the situation of most "leftists."

Kuwait is an oil rich country governed by an undemocratic elite. The U.S. is presently the world's major imperialist nation and has shown a willingness to impose its imperial design by force on Panama, Grenada, Nicaragua, etc. Unfortunately the world is an immoral place. International politics often makes for uncomfortable bedfellows. This shouldn't dissuade us, however, from seeing reality.

The peace camp, while courageous, is naive to the extreme. While war is terrible and destructive, let us look at the alternative. Sanctions in this situation cannot be compared to the South African situation. The South African regime is "changing" (and I'm not sure in response to economic sanctions) after a decade of sanctions. Although racist and non democratic in the majority population sense, the South African government nevertheless is responsive to its constituency (whites). Iraq cannot be said to have a constituency imposing constraints on its leaders. South Africa did not invade a neighbour. What would be the response of "peaceniks" if South Africa invaded Mozambique? Would you still be calling on giving sanctions a chance? This is not Iraq's first attack on a neighbour.

Could the world maintain tight sanctions against Iraq for long? The value of arms shipments makes this seem unlikely to me. Even Iran got spare parts for American equipment during its war with Iraq. Iraq is not terribly concerned about the comfort of its citizenry and I think this makes sanctions a relative non starter.

When we talk of the destruction wrought by war, what about the destruction of the status quo? How would you like to be living in Kuwait? What of the cost of maintaining a military presence in the Gulf to enforce the blockade?

I know war is "messy" but where does this liberal-pacifist ideology about war come from? Ultimately a failure to meet aggression with force is simply a call for the status quo. I'm sure my comments are tempered by my parents' experience as concentration camp inmates for 5 years during the Holocaust, but I wonder where you would have stood in 1939 when Germany invaded Poland. I'm afraid my parents would have been a casualty of your peace efforts.

I know the Americans are motivated by oil interests and the like. I also support an international conference on the Middle East. I am critical of the Israeli occupation of the West Bank. But don't think that Saddam invaded Kuwait to force a peace conference. And don't think that useful negotiations are possible with Saddam. At least the war has significant U.N. involvement (although unfortunately under U.S. leadership).

My mandate as a physician is exactly "to preserve meaningful life." That's why I am ambivalent about this war.

Fred Freedman

Letter motivated by desire to avert war

To: Dr. Fred Freedman

Dear Fred:

Re: Your response to our letter to Brian Mulroney about the Gulf crisis

The Steering Committee regrets that you feel "democracy and open discussion within the MRG have not been served" in connection with the letter we wrote to the Prime Minister on the eve of the Gulf War. We feel that we acted in a responsible way given the urgency of the situation. None of us had anticipated that events would so quickly come to a head, as we gathered that evening for an ordinary Steering Committee meeting. Our feelings on the issue may differ from yours, but we are sure you will agree that the occasion could readily be considered a "public health emergency" -- especially in view of what we know now about the subsequent overall costs of the war in terms of human suffering and life.

It was in this context that the Steering Committee, after considerable dis-

Necessary to fight for peace

Dear Dr. Kirpalani and Co-Signatories,

Thank you for your correspondence on the Persian Gulf.

Canada is a peaceful country and Canadians do not want war. When it comes to the defence of our values and beliefs, however, Canada is not a neutral country, as we remember formally every November 11. We know from our history that sometimes it is necessary to defend our values and fight for peace. Regrettably, this is one of those times.

Nothing in our experience as law-abiding, peace loving citizens of a democratic country like Canada prepares us to respond to a man as dangerous to world peace as Saddam Hussein. His actions demonstrate clearly his indifference to the welfare of his own people and his capacity for unprovoked aggression, terrorism against civilians, and environmental vandalism on a catastrophic scale.

His record is truly appalling. He has turned his country into a brutal police state, launched an eight-year-long war with Iran which cost more than a million casualties, and used poison gas against his own people. His forces have occupied Kuwait and perpetrated terrible atrocities against its people, as documented by Amnesty International. He has launched missiles against population targets in cities in Saudi Arabia and Israel, the latter a non-combatant country. He has abused prisoners of war, flooded the Persian Gulf with oil, and threatened repeatedly to use chemical an biological weapons. He has also made his intentions to obtain nuclear weapons clear.

With each passing day, it becomes increasingly unmistakable both how totally determined he is to stay in Kuwait and how totally ineffectual economic sanctions alone would have been in persuading him to withdraw his forces from Kuwait. All entreaties to him to be reasonable have fallen to deaf ears. Wishful thinking on our part and pacifist policies – no matter how well-intentioned they may be – against any war would only be interpreted as weakness on our part and make him more dangerous.

Following the invasion of Kuwait, the Canadian government carried out a two-track policy. We worked diligently for peace, especially at the United Nations, by helping to draft and pass 12 Security Council resolutions requiring Saddam Hussein to withdraw from Kuwait. We also prepared prudently for hostilities.

Diplomacy was given every chance but proved inadequate in the face of Saddam Hussein's intransigence. Canada became involved because Saddam Hussein's invasion and brutalization of Kuwait is wrong and the world has amoral obligation to stop him. Also, Canada has a vital interest, as a country with modest military means and dependent itself on the rule of international law, in the upholding of the Charter of the United Nations. The basic mandate of the United Nations in Article 1 of the U. N. Charter is for member nations to cooperate collectively to deter aggression and, if aggression happens, to suppress it. It is important to Canada that the United Nations respond successfully to this first challenge to its authority since the Cold War ended. Otherwise the United Nations would be condemned again to impotence, incapable of protecting any country's security, including Canada's, and discredited for decades to come.

The issue of Canada's support for U. N. efforts to end Saddam Hussein's invasion of Kuwait has been voted on by the House of Commons on three separate occasions: October 23, November 29 and January 22. The house has debated Canada's participation in the Gulf crisis three times for about 75 hours, more time than any other democratic Parliament.

I know that all Canadians hope and pray that this war will end as quickly as possible and that our servicemen and women serving so courageously in the Gulf will be home again soon.

The attached texts, which are copies of the statements I made recently, provide further details on Canada's position on the war in the Gulf.

Yours sincerely,
Brian Mulroney

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cussion, agreed to send the letter, despite the absence of official MRG policy in this area. We would not ordinarily make pronouncements on political issues beyond the MRG mandate.

We do not wish to argue that the war was somehow "wrong" or "right", but only that we did not think then, and we do not think now, that adequate efforts were made to avert it.

Additionally, we were personally moved by the willingness of one of the Steering Committee members, Robbie Chase, to go to the scene of the imminent fighting as a member of the "Gulf Peace Team". We felt that our relatively neutral letter, urging that every effort be made to find a peaceful solution to the problems before war was declared, was a very reasonable action for us to take as a Steering Committee. There simply was not time (nor was there a means) to phone any representative sample of our large membership to ensure that everyone agreed with the wording of the letter.

Again, we regret that you seem to feel that our action was not consistent with the principles of the organization and that our procedure was somehow improper. We feel comfortable with both, in retrospect. We do invite you to have your letter published in the next issue of the newsletter as a means of informing the membership of the issues you have raised.

Yours sincerely,
MRG Steering Committee

Journal Review

Medicine and technology assessment

Linton AL, Naylor CD. Organized medicine and the assessment of technology. Lessons from Ontario. N Engl J Med 1990;323:1463-1467.

This paper is fascinating on a number of counts. First, it results from the collaboration of two very different academic Canadian physicians. One (Linton) one of the more progressive voices within the OMA, nevertheless preaches the OMA's essentially conservative philosophy. The other (Naylor) is a politically progressive clinical epidemiologist who has been heavily involved with people like Michael Rachlis and John Frank in developing guidelines for clinical practice.

In their NEJM paper, Linton and Naylor suggest that, because the government is the purchaser of almost all essential medical and hospital services, the diffusion of technology would be more easily controlled. They suggest that, despite this, the Canadian approach to technology diffusion is at best haphazard.

The paper tells their version of the story of the diffusion of three medical technologies. The first was low-osmolality contrast mediums (LOCM) which result in fewer anaphylactic reactions than standard mediums. LOCM quickly became the standard for radiological procedures, despite enormous cost to hospitals and to the government. The minimum estimated cost-utility of conversion to LOCM is $64,000 per quality-adjusted life year gained. The authors describe the decision as dubious. They note that in the process of decision making there was no explicit recognition of the debate over marginal costs, and no attempt to examine the impact of cuts in other hospital services necessitated by the use of LOCM.

The second story has to do with thrombolysis for myocardial infarction. Thrombolysis for patients with acute myocardial infarction has been shown to save lives. Tissue plasminogen activator (TPA) is approximately ten times more costly than streptokinase, the standard drug for thrombolysis. The drug has putative advantages in terms of safety and efficacy which a critical reading of the literature would suggest have not been proven. A panel of experts convened by the OMA agreed with the government's decision that no extra funds would be made available for TPA. The result has been limited use of TPA, with continued reliance on streptokinase. Very large randomized trials are currently evaluating the relative merits of the drugs. The authors note that in a subsequent survey, 94% of physicians opposed direct government involvement in the development of subsequent guidelines.

The third tale is that of the development of recommendations for screening and treatment of hyperlipidemia. These recommendations were once again a product of collaboration between the OMA and the government. A systematic review of the literature resulted in recommendations against universal screening, and for selective case finding. The recommendations of the report, which was endorsed by the Ministry of Health and the OMA, were much more conservative that those produced by other bodies dominated by lipidologists rather than clinical epidemiologists. Lipidologists have criticized both the content of the report and the process their exclusion from the process by which it was developed.

The authors discussion includes a defense of the recommendations of the lipid screening group (which Naylor led) and an advocacy of relying on experts in methodology and policy rather than consensus panels to make policy recommendations. Both these positions are, in my view, highly appropriate. They also conclude that rational diffusion of new forms of technology is difficult to achieve, even within single-payer systems. They identify incomplete data, powerful interest groups promoting diffusion, inadequately defined goals of health care, and competing philosophies within the profession as factors which contribute to this difficulty. They also note that physicians may not take kindly to constraints on their practice that may follow from mandated practice patterns. They note, however, that the alternative is chaos and irrationality.

This is an interesting and thoughtful paper, and the only problems I have with it are its tone. I believe that one could, with equal validity, draw the following conclusions from their examples. First, the government and the profession can work together to develop guidelines. Second, these guidelines are likely to generate antagonism, but will nevertheless have high credibility. Third, if disinterested methodologists review the evidence and lead the development of guidelines, the results are likely to be more rational than those developed by content-area experts. Fourth, the recommendations can impact significantly on practice. Fifth, a universal single-payer system is probably the only way in which rational dissemination of technology can be achieved. These conclusions should reinforce the MRG in its current direction which emphasizes working with the provincial government to achieve higher quality care.

Gord Guyatt

The view from Queen's Park

"Are you still practicing as a doctor? I am often asked since being elected.

It has soon become evident that an MPP's job is full time. The combination of responsibilities at Queen's Park and in the riding would make it impossible to engage in a profession as well.

In some ways an MPP's job is a complete change to an unfamiliar field. In other ways it flows naturally from what one does as a family doctor.

At Queen's Park when the house is in session one's time revolves around the legislature. The daily routine of members' statements, question period and debate is a fascinating, often entertaining occasion. I would encourage anyone to come down and watch – it's probably the best free show around.

(And of course you can watch it live on television. My colleagues and I realize that a remarkable number of people do watch regularly and comment on our demeanor and the ties we are wearing.)

During the winter recess there are house committees. These do not attract the same attention, but they are open to the public and can actually be very interesting. They are quite small and informal, so it is easy for the public to speak to members. Delegations and witnesses often have the opportunity of making presentations to committees and the experience does not seem intimidating.

Continued on next page

Foreign medical graduates seek recognition

To Medical Reform Group Steering Committee:

Please find below a copy of a hand-out describing the goals of our organization, the Canadian Association of Unsponsored Foreign Medical Graduates. This hand-out was distributed at the MCCEE in Toronto and Vancouver in March.

We have also prepared a questionnaire for FMG's-in-training which has been distributed in the Kingston area, and would be happy to supply interested persons with a copy. Could you let the MRG know about our organization? Any suggestions about reaching prospective members would be appreciated.

We have some questions of MRG about unsponsored foreign medical graduates. We are wondering if MRG has at any time looked at the role of the unsponsored FMG in the Canadian medical care delivery system? Your deliberations, statements and articles would be of interest to us.

The report of the Ontario Task Force on Access to Professions and Trades was submitted October, 1989 to the Minister of Citizenship. Has MRG considered its recommendations regarding FMG's?

We are aware that MRG is concerned with the fee-for-service system and, given the increasing tendency of physicians to put life style on a par with income, has MRG looked at the manpower requirements that will ensue? Do you think that FMG's could fill the places that will become available?

With regard to the underserviced areas does MRG feel that changes in licensing and/or training to allow for the recruitment of FMG's is a viable option?

We look forward to your reply.

Yours sincerely

Vivian Hylands

The following is a description of the CAUFMG enclosed with the above letter:

CAUFMG is a new organization existing solely for the purpose of seeking fundamental justice for FMG's in Canada. It has become obvious over the last few years that medical licensing, examining and training authorities have their own changing agendas regarding FMG's. Little, if any, real progress on our problems can be made without an organization of our own. In fact, it's truly surprising that no such organization exists already and that's a measure of the fear and competition that divides us. Surely it is time to unite. Even the government of Ontario's own Task Force on Access to Professions and Trades has recommended that all Canadian doctors should be treated equally, regardless of national origin.

Currently there are refugee physicians, Canadian citizens, who are denied not only the right to practise the profession they have spent many years training for but even the right to retrain for that profession. Could this contravene the Canadian Charter of Rights and Freedoms? We'll never know unless we organize.

You are about to take the first big step to practising in Canada by writing the MCCEE; had you taken the advice of Employment & Immigration Canada you would probably not have taken even this step.

You are probably worried about all the future steps you may have to take when you pass the MCCEE, such as Pre-Internship Programmes. But do you know that there are training programmes in Canada which are accessible to FMG's directly upon passing the MCCEE? Without an organization, identification of these programs will never be made widely available to FMG's.

At present CAUFMG hopes to use three broad paths to achieve our goal of a level playing field for all Canadian doctors.

1. Collect and disseminate information to our members about existing examination, training and licenser opportunities.

2. Lobby for change by participating in the complex structure of professional organizations, government departments, training faculties, examining and licensing bodies that regulate medicine in Canada today.

3. Investigate the legal basis for the current policies regarding FMG's in Canada and legally challenge these policies where appropriate.

All interested persons please send a stamped, self-addressed envelope to the following address and, if you have the time, tell something about your hopes, your background and the problems you have encountered so far.

CAUFMG
500-2319 St. Laurent Blvd.,
Ottawa, Ont. M1G 4K6

Recently there has been a committee looking at the government's rent legislation and there have been lively presentations from landlords and tenants groups.

I have been serving on the committee on government agencies, which examines bodies such as the LCBO, the Ontario Municipal Board and a whole host of others. Anyone who is interested in how they work or who is being appointed should get in touch with me.

None of this is much like my previous work. But other parts of the job are not that different.

In the riding and at Queen's Park individuals and groups come with problems to be dealt with. Sometimes the problems can be solved with advice, sometimes they need referral. We get inquiries about housing, about proposed government policies, about topics that one had taken for granted in the past.

It's part of the job to be tested and if we don't always know the answers, we are learning all the time about where to turn for help in the system.

My assistants in the riding office are Kathy and Virginia; at Queen's Park we have Larry and Lisa. We want to hear people's concerns – to help some as citizens of Scarborough and the province. Government needs to hear from as many people as possible to plan for a better future for us all.

[The riding office is at 4403 Kingston Rd, Unit 5, Scarborough, Ontario, M1E 2N6. Phone 281-2787. The Queen's Park number is 327-4338. Fax 327-4484. Besides being a member for Scarborough East, Dr. Frankford is Parliamentary Assistant to Evelyn Gigantes, Minister of Health.]

Dr. Bob Frankford, MPP

Request for Assistance on Psychiatric Drugs/Withdrawal

I am writing to ask for your assistance. Specifically, I am requesting names and telephone number of MRG physicians who are willing to help patients withdraw from psychiatric drugs. As you may know, many people have become addicted to "minor tranquilizers" such as Valium, as well as some of the antidepressants and even neuroleptics ("anti-psychotics" or "major tranquilizers"). The vast majority of these people, I have good reason to believe, can not find a doctor sufficiently knowledgeable about psychiatric drugs and willing to help them withdraw from these very powerful, debilitating and brain-damaging chemicals. When people call me asking for the name(s) of doctors willing to help them, I cannot help them because I don't know any such doctors. Other advocates and critics have told me very similar stories. This is unacceptable as well as tragic.

I would appreciate your reply concerning this huge and chronic gap in preventive health care. I also suggest you look for and read my recent article critiquing psychiatric drugs, "Chemical Lobotomies", which is scheduled to be published next month or this coming May in the magazine *Canadian Dimension*. In addition, you may obtain a copy of the unpublished brief, "Psychiatric Drugs: A Public Health Hazard," from Dr. Bonnie Burstow by writing or calling her: Dr. Bonnie Burstow, 441 Clinton St., Toronto, Ont. M6G 2Z1, (416) 538-7103. The cost of one copy of this brief is $3.50 including postage. Perhaps the most outstanding book in this area is the one titled *Psychiatric Drugs: Hazards to the Brain* by Dr. Peter R. Breggin (psychiatrist), Springer Publishing Co., 1983. I strongly recommend it.

I hope to hear from you shortly.

Don Weitz

(P.S. I am still very disappointed that the Medical Reform Group of Ontario does not consider the many serious risks and medical complications ("side effects") of psychiatric drugs a priority issue deserving of serious study, not to mention public education and public criticism.

[Editors' Note: Readers wishing more background information may also wish to refer the exchange of letters between Mr. Weitz and the MRG Steering Committee in the August 1989 issue of Medical Reform.]

The MRG and the State of Maine

The MRG is getting increasingly involved with the struggle for a universal-entitlement health care system in the United States. This report is submitted to inform MRG members of interaction we have had with groups in the state of Maine, and in the process to mention what has been happening in the local MRG in Hamilton.

In September of 1990 I attended a conference of the Maine Citizens for Affordable Health Care, a coalition group of over 30 agencies and organizations. One of these organization is the Maine branch of the Physicians for a National Health Plan. This group has recently grown rapidly, and now includes 125 physicians. A leader of the is group, Dr. Cliff Rosen, decided after this visit that his political effectiveness would be increased by a first-hand look at the Canadian health care system. Cliff visited McMaster during the week of February 11. He met with a number of clinicians and administrators at McMaster, in addition to a number of MRG members. These included Rosana Pellizzari, who showed him the Hamilton North End Community Health Centre, and Haresh Kirpalani. Cliff also addressed a local meeting of the Hamilton MRG. The essential message of the talk was: however bad you thought the American system was, it's worse. Incidentally, the medical students at the meeting felt there was a growing interest among their colleagues in the MRG, and I am going to meet with interested students in March. Cliff felt his visit was extremely stimulating and worthwhile.

During the week of February 25, I returned to Maine as a guest of the Physicians for a National Health Plan and the Citizens for Affordable Health Care. Events included interviews with three radio and two television stations, addresses at Medical/Surgical grand rounds in Bangor and Waterville, speaking to 150 members of the Bangor Rotary Club, meeting with residents and faculty of the Augusta/Waterville family practice residency, addressing a meeting of the Citizens for Affordable Health Care at the State Capitol, and speaking to the Banking and Insurance joint committee of the Maine state legislature (the committee primarily responsible for the development of a new health plan for the state of Maine. The primary topic of each of these presentation was the Canadian health care system.

The context of the visit was initiatives being brought forward by the Citizens for Affordable Health Care. The group has already engineered two major legislative victories. The first was the passage of the "Maine Health Plan" whereby poor individuals not eligible for Medicaid (which provides health care to the poorest of the poor) by virtue of their incomes of up to $18,000 were to be provided with benefits comparable to Medicaid. The second was legislating prohibiting group health insurers from denying coverage, in certain circumstances, to people with pre-existing health problems. This legislation stunned the insurance industry. Joe Ditre, the leading organizer for the group, felt that these legislative successes pointed out the tremendous amount of grassroots organizing that the coalition has performed and its ability to organize/mobilize large numbers of Mainers.

The group's newest initiative is legislation that is now being introduced which will establish a committee to iron out the details of a universal single-payer system for Maine which they hope to introduce at the beginning of 1992 and implement early in 1993. The proposed legislation specifies that the ultimate plan must provide universal access to comprehensive benefits; be administered by a publicly accountable, non-profit agency; have public and progressive financing; and included cost containment measures. There are four legislative sponsors, and strong support in the legislature. The primary purpose of the meeting of the Citizens for Affordable Health Care I

attended was to announce the new legislation which the group is proposing.

My sense was that most of those with whom I spoke have accepted the necessity for major change in the U.S. health system, which is clearly a disaster. The physician groups were extremely attentive. They were skeptical, but not overly hostile or defensive. The discussion with the Rotarians was lively, and punctuated by a somewhat hysterical outburst by a physician who makes a large profit as a function of partial ownership of two MRI scanners in Bangor. Primary caregivers in Maine get the worst of the American system (dealing with many patients who have no insurance, and the immense paper work and restrictions imposed by the insurance industry, with resultant huge overhead costs) without the major benefit (i.e. the income -- they earn a mean of $59,000 per year). As a result, when I spoke to the family medicine residents and faculty I was talking to a largely converted audience.

The most exciting part of the trip were the events at the state legislature. The meetings occurred in an atmosphere of high drama. Since the Maine Health Plan had been introduced in the autumn, there had been 11,000 enrolees, in contrast to the 1,000 or so that were expected. This reflected the immense need for the program, but the Republican Governor had concluded that the state could not afford the program and had unilaterally announced its cancellation. The day before the meeting, a bipartisan committee had hammered out a funding proposal to maintain the Maine Health Plan that had forced the Governor to reconsider his position. When I left, it appeared that the Maine health plan was still alive.

The meeting of the Citizens for Affordable Health Care was fascinating. This is a truly grass-roots group including organized labour, seniors, disabled, gay and lesbian, small business, local health advocacy, and health professional organizations. Perhaps because of their recent success, and the announcement that the Maine Health Plan had apparently been saved, the atmosphere of this meeting was tremendously upbeat. Brief addresses from two state senators sponsoring the new legislation, the head of the Maine AFL-CIO, a doctor from the Physicians for a National Health Plan, were all greeted with prolonged and enthusiastic applause. The most moving speaker, however, was a lady of about 55 suffering from both diabetes and rheumatoid arthritis who had received benefits as a result of the Maine health plan. "If the Maine Health Plan is cancelled," she said, "I don't know what I'll do." The group was keenly interested in the Canadian system, and questions continued for an hour, much longer than had been planned, after I spoke.

When I spoke to the Banking and Insurance committee I found a group for whom much of the information I provided was news. They were especially interested in the relative costs of the Canadian and American system, and also in the fact that Canadian physicians face far less interference in their day-to-day practice than do their American counterparts. The most difficult questions to deal with were those observers from the insurance industry who provided anecdotes concerning inadequate care that led Canadians to seek care in the United States. Fortunately, a local representative from an area near the Maine/New Brunswick border reported that there was more traffic in the other direction. The most gratifying response to the presentation was from a Republican state senator, who said that if documentation in support of what I had said about health costs could be provided, he was convinced. On providing the representative with a paper by health economist Bob Evans and colleagues, Joe believed he had won another ally.

The opportunity to be of service to a broad-based coalition addressing an urgent need was very satisfying. It is likely that the MRG will have more such opportunities in the future.

Gord Guyatt

The Globe and Mail, Thursday, December 20, 1990

Groups join to fight for medicare

Health-care activists warn of threat to jewel in crown of social programs

BY ROD MICKLEBURGH
Health Policy Reporter

Health-care activists are banding together to fight what they believe is a grave threat to medicare, the prize jewel in Canada's crown of social programs.

At a hastily called press conference in Vancouver this week, a patchwork coalition of 15 B.C. groups warned that the public health-insurance system is facing the deepest crisis in its 20-year history.

"Canadians may soon be faced with 10 different systems and 10 different standards across the country," said Sharon Manson Willms, a social economist at the University of British Columbia and a member of the Canadian Council on Social Development.

In Ottawa, the Canadian Health Coalition, representing numerous national organizations, has prepared pamphlets, a network of speakers and a slide show. "We are trying to get the message out to people about what is going on, that medicare is being threatened," said coalition executive co-ordinator Pam Fitzgerald.

Activists have been concerned since March, when the federal government introduced a complicated piece of legislation (Bill C-69) to restrict its cash contributions to provincial social programs.

But their campaign did not begin to catch fire until this month, when some provincial finance ministers meeting in Winnipeg raised the possibility of the provinces taking com-

A few days later, Quebec announced it will begin charging $5 user fees for non-emergency visits to hospital emergency wards.

"It's all coming together at once, and that's triggered a number of people to become quite alarmed," Ms. Fitzgerald said.

Valerie Sims, executive director of the Canadian Council on Social Development, which has printed 125,000 pamphlets outlining the perceived dangers of Bill C-69, said these recent events are a clear indication of the financial pressures Ottawa is exerting on provinces.

"Universality and portability are going to be nibbled away at."

That may be happening already in Quebec, where Intergovernmental Affairs Minister Gil Rémillard has called for the scrapping of the Canada Health Act, the legislation governing medicare.

"Simply put, we can no longer afford the system the way we know it today," said Russ Williams, parliamentary assistant to Quebec Health Minister Marc-Yvan Côté.

"The virtue of universality and our ability to pay for it are on a collision course. This is an issue that touches every province," he declared. "We may have our differences in how we deal with the situation, but there's no doubt the crisis is coming and must be dealt with."

Bill C-69 was passed in the House of Commons last June while the country was distracted by the Meech Lake crisis, but is still before the Senate.

complex formula under which Ottawa helps the provinces pay the cost of health care and post-secondary education. It would freeze Ottawa's contribution for two years, and then tie future increases to annual increases in the gross national product minus 3 per cent.

Activists argue that this will not be enough to keep up with rising costs as the population ages, hospital waiting lists increase, and doctors, nurses and other medical workers keep demanding higher salaries.

They also note that the formula will result in an ever-diminishing amount of actual cash handed over to the provinces by Ottawa, with the rest of the financing made up by an ever-increasing amount of tax revenue earned by the provinces through federal tax points.

Tim Sale, a Winnipeg private consultant, has predicted that some time early next century no cash at all will flow from Ottawa to the provinces for health care. That is significant because the Canada Health Act's ban on extra-billing and user fees is enforced by Ottawa's ability to reduce cash transfers to any province violating the act.

If there are no longer any cash transfers, financially beleaguered provinces will be free to erode medicare's long-standing national standards, activists argue.

"At some point fairly soon, provinces are going to say 'take your Canada Health Act and blow it out your ear,' " Mr. Sale said.

And, Ms. Manson Willms said, "without the possibility of fiscal

penalty, there is nothing to deter provinces from allowing user fees, extra-billing or the setting up of a two-tier system."

She said Canadians have been slow to understand the dangers because Bill-69 is so difficult to understand, littered with such phrases as "the cube root of a fraction."

"It all seems like obfuscation, but we're starting to learn that what that obfuscation means is the destruction of Canada's medicare system."

In Ottawa, federal Health Minister Perrin Beatty rejected allegations that government policies are threatening medicare. "Certainly there are pressures," he said in an interview, "but do I believe that medicare is in crisis? No, I do not."

The government remains totally committed to medicare as a universal health-care system accessible to all Canadians, he said. "It is a human entitlement in our country, just like the justice system."

Mr. Beatty said provinces should stop complaining about the freezing of transfer payments. "Right now, 35 cents of every federal tax dollar is going to cover debt-servicing charges. That's a burden everyone has to share. Yet we are still putting in $14-billion this year for the provinces. That's a very significant contribution."

Asked about the prospect of cash contributions being wiped out, he said that is a problem to be solved "over the years ahead. Inevitably, there will have to be discussions between the finance ministers ove[r] the future of transfer payments."

The Boston Globe

THURSDAY, NOVEMBER 15, 1990

Health-care crisis forecast in Mass.

Conference cites rising costs, more uninsured in urging Canadian-style plan

By Dolores Kong
GLOBE STAFF

An impending health-care crisis in Massachusetts, reflected in the rising number of medically uninsured people and sky-high costs, calls for drastic reform in the shape of a Canadian-style health system that covers everyone, a conference of health activists was told yesterday.

"A crisis is looming. Costs are out of control. Unless we do something about cost we won't be able to fulfill the dream of universal access," said Robert Restuccia, executive director of Health Care for All, a nonprofit umbrella organization. The group's first annual meeting was attended by more than 100 people.

A proposal to control Massachusetts' costs through a Canadian-style single-payer system is being drafted by Health Care for All and other groups. The plan would set up a single corporate entity to pay all health bills, eliminating the present system of multiple insurers.

The proposal would go well beyond Massachusetts' existing universal health-care law, a groundbreaking measure enacted in 1988 to reduce the number of uninsured by re-

'A crisis is looming. Costs are out of control. Unless we do something about cost we won't be able to fulfill the dream of universal access.'

ROBERT RESTUCCIA
Executive director of Health Care for All

charge. The law, which has not yet been fully implemented, faces an uncertain future under the administration of Governor-elect William Weld, who has opposed the law.

The proposal for a Canadian-style system will be presented to a special legislative commission within the next few weeks but is expected to be opposed by some insurance companies, hospitals and physicians.

Rep. John McDonough, the Democrat from Jamaica Plain who is cochairman of the commission, told the gathering: "I am hoping to embrace a single-payer bill ... We know from other experiences in Canada and other nations ... there is a saner, more rational way to pay for health care in this country. Do we have the political will and the political clout to do this?"

change can be seen in the rising numbers of patients who have no insurance, said the unit's director, Dr. Peter Moyer. In the last six years, the number of uninsured patients has climbed from 40 percent to 60 percent.

"There's no way our population is able to pay for health care out-of-pocket," Moyer said. "I've long been an advocate for health care for all and for a system much like the Canadian health system."

Helen Nelson, 77, a vice president for Massachusetts Senior Action Council, said she and her husband worry constantly that a hospital charge could eat up a month's Social Security check.

"The elderly can't afford to buy health insurance" to cover expenses

pitalization and medications, Nelson said.

Dr. Gordon Guyatt, an associate professor at McMaster University in Ontario and a specialist on his nation's system, said the Canadian national health system provides a model for addressing the problems of poor access to care and rising costs.

"If you go to a hospital in Canada, you pay nothing," Guyatt said. "When you go to a physician, you pay nothing. No copay. No deductible. You're 100 percent covered."

Canada has been able to provide universal access without driving up costs by eliminating the overhead of multiple insurers, Guyatt said. In the 1960s, Canada and the United States were neck-and-neck in the percentage of the gross national product they spent on health care.

Today, he said, the United States spends close to 12 percent of its GNP and has an estimated 37 million people who are uninsured, while Canada spends about 9 percent of its GNP and has everyone covered, Guyatt said.

He acknowledged that under the Canadian system some patients must wait more than two months for elective surgery and that some doctors have to call around to find an

Boston Herald

11/15/9

Universal health care advocates look to Canada

By SUSAN BRINK

In developing a plan for universal health care, Massachusetts may have erred by concentrating too much on improving access to care and not enough on containing costs, say universal health-care advocates.

But a crisis is looming of such undeniable proportions, that — mistakes aside — the push for universal health care must continue, incorporating cost savings into plans to make sure that everyone has access to medical care, said Rob Restuccia. He is executive director of Health Care for All, a consumer coalition behind the drive for universal health care.

Restuccia hosted the group's annual meeting yesterday, where experts compared the health systems in the United States and Canada.

At the time of the meeting, 15 percent of Massachusetts citizens are either uninsured or underinsured; the state has the highest level of per capita health spending in the country ($3,031 per person); and Gov.-elect William F. Weld has threatened to repeal the universal health-care law.

Dr. Gordon Guyatt, a Canadian physician, said Canada's system could offer some guidance.

"For most Americans indoctrinated by private enterprise, it's inconceivable that a system can give quality care, cover everybody and still cost one-third less than the American system," said Guyatt, "but that's the reality."

In spite of state and national economic crises, the time may be right to finally see national health insurance debated fully, and ultimately accepted, said Dr. Arthur Flemming, former secretary of Health Education and Welfare, and a 50-year advocate of national health insurance.

"Martin Luther King Jr. spoke of the 'fierce urgency of now.' For the people being passed over, there's a fierce urgency of now. Polls indicate we have a lot of people fed up with our patchwork health-care system," said Flemming.

He predicted that 1991 would see a strong congressional debate on national health-care proposals that came out of a congressional committee chaired by the late Rep. Claude Pepper (D-Fla.).

Guyatt said criticism by the American Medical Association of the Candadian system represents "lies and distortions, to summarize succinctly." The AMA has criticized the Canadian system, saying that patients have to wait for care and the quality is not as good as in the United States.

Flemming said criticism of Canada glosses over the underlying problem of the system at home. "The thing we have to keep in mind in this country is, our basic fundamental weakness is that we have got 38 (million) to 40 million people who don't have access to any kind of health system, public or private,"

"We will either get action on this, or it's going to emerge at the number one campaign issue of the 1992 election."

22/9/90

Court overturns OHIP billing decision

By LOUISA BLAIR

An Ontario Supreme Court decision to overturn an OHIP ruling stopping a physician from charging fees to a patient for uninsured services is receiving mixed reactions from the medical profession.

Dr. Marshall Redhill, a Scarborough obstetrician, was charging patients a one-time fee of $200 to cover uninsured services such as advice over the phone, paperwork and counselling by a nurse. OHIP ruled that it would only pay for advice given over the phone if details of the call are noted.

Dr. Miriam Divinsky, spokesperson for the Ontario Medical Reform Group, is concerned about the court's decision to overrule OHIP. She said that it is routine to chart every phone call. "It's a weak argument. The doctor is too busy to chart but evidently not too busy to bill."

The Ontario Medical Reform Group, formed in 1979, believes that health is a right, and that universal access should be guaranteed. The organization was active in condemning the doctors' strike of 1986.

Dr. Divinsky fears that the court ruling on the Dr. Redhill case appears to condone extra-billing.

Peter Fraser, executive director of the OMA, argues that Dr. Redhill was not extra-billing his patients. He said that blanket billing for all uninsured services is allowed under provincial legislation and Dr. Redhill was simply "following the letter of the law". He added that most doctors are prepared to waive the fees for underprivileged patients.

But Dr. Divinsky claims that patients who don't pay the fee may fear that their rapport with the doctor will suffer. "That rapport is particularly crucial in antenatal care," she said. "Patients don't dare jeopardize that relationship by refusing to pay." As well, elderly or handicapped patients may be humiliated by having to ask for an exemption, she added.

According to Dr. Divinsky, overhead costs for certain operative procedures performed in a doctor's office are provided by OHIP under the Independent Health Facilities Act (Bill 147). "So there's no more excuse for extra-billing," she said.

However, Fraser says Bill 147 only offers doctors a low fee of $10-20 for performing a limited number of procedures, such as vasectomies or removal of minor skin lesions.

In April, OHIP attempted to clarify the definition of an insured service, and published an amended list of uninsured services. Executive director of Ontario's health insurance division, Dr. Bob MacMillan, said he hoped the amendments would end the arguments over what can be charged to patients. Since 1986, OHIP has received a total of 1651 complaints concerning extra-billing.

Dr. Divinsky is worried, however, that a tightening of the definitions could simply usher in a new wave of "creative billing". She envisages doctors charging patients for paper gowns, tongue depressors, or rent on chair space in the waiting room.

Dr. Bob MacMillan

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