MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

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Medicare is in danger: What we can do to save it

A statement from the Ontario Health Coalition

Medicare in danger? A frightening thought, and a prospect that most Canadians would dismiss out of hand. After thirty years of medicare, access to quality health care services is so much taken for granted that even those who would limit access speak in terms of a 'sacred trust.'

Over the past decade, funding for health care, among other social programs, has been gradually restructured in the name of restraint. Where expenditures have continued to grow most markedly are not in the areas of prevention and enhancing the quality of life, but high technology specialities relating to diagnosis and acute care therapies. While we have also been treated to a rhetoric of democratization and decentralization linked to client-sensitivity, the evidence in many areas suggests that such trends have been primarily motivated by a short-term view if the balance sheet and a very narrow approach focusing on acute care.

The Ontario Health Coalition brings together organizations and activists in Ontario committed to a high-quality, cost-effective system of health care integrating physical, emotional and environmental good health and sensitive to gender and culture.

We represent health care providers and health care consumers. Our membership includes trade unionists and other professionals, women, seniors and others committed to equality and social justice. We are committed to keeping and improving our Canadian medicare system.

At the same time, we believe that our health care system can be more responsive and effective in serving our health needs and goals and that a genuinely democratic decision-making process to achieve those goals will serve us best.

We believe effective advocacy for high quality health care requires coordinated pressure on all levels of government, including the local authority, the province and the federal government.

In the context of the current recession and global restructuring in response to the neo-conservative corporate agenda, moreover, we are concerned that governments under intense fiscal pressure will make arbitrary cuts and implement short-sighted management strategies which will be difficult to reverse.

The Ontario Health Coalition joins with other members of the Canadian Health Coalition in calling for a new approach to health care, consistent with the reaffirmation and enhancement of the five principles of Medicare:

Future of medicare on the line

What does the British experience tell us about the future of medicare here in Canada?

That's the question the MRG's two Spring general meetings will be looking at later this month.

The Tuesday May 19 meeting will be looking at recent developments in the British National Health Service.

Then, on Thursday May 28, we will be looking at medicare in Ontario together with guests from the Ontario Health Coalition.

The May 19 meeting will take place at 8 p.m. in the Debates Room of Hart House at the University of Toronto. (Hart House is on Hart House Circle, south of Hoskin Avenue.) The Steering Committee will have a dinner meeting at 6:30 in the small dining room at Hart House; anyone who is interested in attending the dinner portion should call (416) 588-9167 in advance because dinner must be ordered in advance.

The featured speaker on the National Health Service will be Gavin Mooney, the Director of the Health Economics Research Unit and Professor of Health Economics at the University of Aberdeen, Scotland. He is the author of over 100 publications in health economics and is co-editor of a series of books on economic issues in health care. He has acted as a consultant to the World Health Organization and the OECD.

The May 28 meeting will take place in Toronto in the chapel of St. Paul's Centre at Trinity, 427 Bloor Street West (one block west of Spadina Avenue). That meeting will begin at 6:30 p.m., and pizza will be ordered in. Business items, including a proposal to increase membership fees from $175 per year to $195 per year, will be discussed from 6:30 to 7:00. A discussion of proposed de-listings of procedures from OHIP is scheduled for 7 p.m. At 8 p.m., two guest speakers from the Ontario Health Coalition will kick off a discussion about the future of medicare in Ontario.▼

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1. **Universality.** Health care must be available to all residents of Canada, on uniform terms and conditions
2. **Accessibility.** Health care must be reasonably available to all residents of Canada close to where they live and work and without direct or indirect charges or other impediments
3. **Comprehensiveness.** Every province insures a full range of services for all residents as required
4. **Portability.** Coverage of health care services extends across Canada.
5. **Public Administration.** Our health care system is administered and operated on a non-profit basis

Reforms to the health care system should strengthen, not undermine these important principles. They should be based on our growing understanding of the social and economic determinants of health, including the maintenance of a healthy environment, rather than uncritical reliance on technology. They should make health care more democratic, empower Canadians to take more control of, and responsibility for, their individual, family and community health. They should also ensure integrated services for children, persons with disabilities, and seniors consistent with maintaining the maximum quality of life for both patients and care-givers.

Here are some specific reforms that would meet these goals:

1. Develop and implement public and medical education aimed at the demystification of diagnostic and therapeutic procedures
2. Implement a network of democratically-run non-profit independent health facilities
3. Where fiscal restraint is indicated, targets and timelines should be decided democratically
4. Develop and implement guidelines for professional practice based on the principle of enhancing the quality of life for all clients; the implementation team should include clinical professionals, government representatives, and democratically chosen public representatives
5. Develop and implement comprehensive and consistent procedures for the funding, licensing, on-going evaluation and quality control of laboratories, pharmaceuticals and other technologies based on demonstration of patient benefit rather than profitability
6. Develop and implement a plan for the informed public participation in and democratization of all health care institutions and community agencies, local boards of health and district health councils, including appropriate mechanisms of representativity and accountability
7. Undertake a comprehensive public review of all legislation relating to the provision of health care in Ontario with a view to determining the most cost-effective procedure of resource allocation consistent with maximum patient benefit
8. Implement rational human resource planning and remuneration for medical professionals, including alternatives to fee for service
9. Develop and implement a plan for wholesale purchase of drugs for use in public facilities and by the provincial drug benefit plan.▼

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. Arrangements to purchase multiple copies of individual newsletters or of annual subscriptions at reduced rates can be made.

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 Fax: (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.

Delisting

The issue raised by this memo on delisting, for myself, revolves around three issues: The first regards the ligitimacy of the government to decide what is funded in health care and what is not. Obviously, such decisions have to be made by the Ministry of Health. However the manner in which these decisions are made is critical. It seems that there was no attempt to consult any section of the medical profession on the nature of these medical interventions. This is problematic to say the least. Furthermore, in the absence of "democratic decision making" channels for the consumer, this is even more problematic.

Secondly, the issue of erosion of universality is raised. If, after all, certain options are delisted, can individuals purchase such services if they have the money to do so? If the answer is yes, then there are definite implications for universality of health care. In a climate where other erosions to the notion of universality are taking place, this is potentially a serious concern for progressives.

Finally, if there are restrictions of OHIP billing for some procedures, it is essential that in rare indications where such procedures are medically indicated, there should be availability under OHIP. For instance, a suicidal patient driven berserk by a cosmetically ugly wound should legitimately have his/her surgery available under OHIP. The Steering Committee felt that this could be vented such that if there were an *excess* of such procedures billed to an individual physician, this could then be challenged. It would be an administrative barrier, but not an absolute impediment of some procedures.▼

— Haresh Kirpalani

Take Stand Against Delisting

We need to be critical of the recently announced possible OHIP "delisting" of certain medical and surgical procedures as posing a serious threat to medicare. Although these procedures have been described as "cosmetic" or "borderline cosmetic" there are, except for neonatal circumstances, appropriate medical indications for each and every one. Delisting means that once outside the OHIP fee schedule, physicians may continue to provide the treatment described, but there will be no limit on the fee that can be charged. Once again we face what we have fought so hard to prevent " a two-tiered medical care system in which the wealthy have continued access and those who cannot afford to pay are denied. We need to call on the NDP government to see this contradiction of their long-standing commitment to three of the principles of the Canada Health Act — that it be universal, accessible, and comprehensive.

We ask that consultation and discussion be initiated in order to assess the medical indications for each of the proposed treatments and that compassionate consideration be given to the inclusion of 'emotional' as well as physical needs in our definition of 'health'. We have a commitment to include in our definition of 'comprehensive' all treatments of proven medical benefit — those that improve quality of life as well as those that prolong it. The serious effects of morbid obesity, deep cystic/scarring acne, sexual dysfunction, and unwanted pregnancy from contraceptive-failure, to name a few, cannot be beyond our arena of concern and care. Patients involved in longterm psychoanalysis cannot be abandoned in the midst of an intensive treatment. We erred in not protesting the delisting of electrolysis — there are patients with indocrine diagnoses for whom this treatment is valid and important.

The argument that those delistings will save the health care system a significant amount of money is unconvincing in a fee-for-service system. That is, most of these procedures are only one of many that a surgeon or specialist is able to provide. Time will be spent providing other 'listed' services within OHIP, perhaps more quickly and efficiently from the point-of-view of the patient, but not, in this way, decreasing health care cost.▼ — ***Mimi Divinsky***

Resource Allocation Questions

I am writing in response to the Resource Allocation item in the April 1992 Newsletter. I would first like to address myself to section 2.4, Evidence-based Decisions.

As a pathologist in practice at academic centres for the last 30 years, I have been impressed by the volume of medical and surgical treatments for which there is no scientific justification. My empirical observation is that a significant proportion of these treatments are in fact very likely unjustifiable. Now that there is a fiscal squeeze on the "Health Care System" (abominable terminology — would "Medicine" not suffice?) it is my view that unjustified treatments should be diligently identified, on a scientific basis, and the Joint Committee should then eliminate them from the OHIP schedule of fees and stop public purse payments for such treatments.

I would like to propose that in order to achieve this goal in time, a principle should be proclaimed stating that "Public funding should be limited to medical and surgical procedures which were demonstrated to be effective by adequate double-blind clinical trials."

It is, I think, well known that clinical trial designs exist for virtually all types of interventions by physicians, as often described by the McMaster Epidemiology group. In areas such as psychotherapy and perhaps others, appropriate clinical trial designs may need yet to be devised, but I see no scientific reason why this should not be possible.

I realize this is a goal that could not be achieved rapidly. Consensus Committees would therefore have to establish a list of procedures which for the present would be justified on a "grandfather clause" basis. At the same time the Ministry of Health and the OMA should jointly provide large funds for peer-reviewed grants to perform the needed clinical trials. I realize also that this would be an extremely unpopular approach, extending and improving the Oregon system.

I noted with interest, for example, that Oregon puts organ transplantation low on the paymaster list. As I practice in a hospital where transplantation is the major priority, I am very conscious of the great need and at the same time the great difficulty of designing clinical trials in this area, and of persuading the clinicians involved to perform them. Nevertheless, I feel that the fiscal crunch on medicine is both severe and permanent, because of the great and increasing cost of contemporary procedures, that such clinical trials may well be the *only* rational approach to the cost of the system in the future.

A second benefit of successful clinical trials would inevitably be the standardization of medical and surgical interventions. Justification of a procedure would be limited to it being performed as in the corresponding clinical trial. This would lead to greater control of any sloppy medicine there may be in practice and provide the design of an audit system based on checking the correspondence of any treatment given to that in the original clinical trial.

Is this pie in the sky? I have little doubt that if 50 or 100 years from now medicine is still practised as we understand it, this approach would be standard. As to new procedures or treatments, they are already at present frequently justified by double-blind clinical trials, or discarded on their basis. Improvements in current procedures would be achieved in the same way. In effect, the Joint Committee would no doubt envisage future second, third, etc. rounds of clinical trials of the same procedures to continue their justified improvements.

I would like to make a few brief comments on other issues raised in the same Newsletter item.

One is the philosophy of the Hippocratic oath. It is based on a physicians' treatment of individual patients: do the best you can for each one. This is fast

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Proposed delisting of procedures

The range of services listed is quite varied and no indication is given as to why these particular procedures have been identified. This issue begs the bigger question of what, if any, criteria exist to provide guidelines for choosing which procedures may be appropriately deinsured. The guidelines should be based on principles such as cost effectiveness, proven effectiveness as a procedure and of benefit to the patient, medically indicated, while at the same time. allowing for recourse on compassionate grounds for individual cases. Obviously, what is meant by "medically indicated" must also be determined. The threat exists of certain patients being caught by Ministry attempts to eliminate insurance expenditures on procedures which are considered to be overutilized. For instance, while the abuse of electrolysis may be widespread (data to indicate this to be so?), in certain sex change patients this procedure may be medically indicated. The physician who practices responsibility should not have the care of his/her patient curtailed because of the exploitive tendencies of some colleagues and the inability of the patient to pay for the services.

Regardless of what guidelines are formulated the process of developing the criteria should occur through a democratic process involving both health care providers and consumers.

If the intent of the Ministry is to reduce expenditures then what is the evidence to indicate that these services are costing the province a disproportionate amount of money for the health care benefits gained? Is there evidence that any, or all, of these procedures are being overutilized by physicians for primarily monetary gains? Should some of the listed services be inappropriately used on a wide scale, which I suspect is the case, and subsequently deinsured, might the concerned physician not just fill the billing void with yet another inappropriately conducted service? How will this malpractice be monitored and curbed? The cut and slash approach will take out both the inappropriate, those not corresponding to the above criteria, and appropriate utilization of these services. The Ministry's current approach to the problem does not address the underlying attitude and behaviour which has been a large part of the problem in the first place.

The question which, in certain respects, is the most disconcerting, is whether this development threatens the universality of health care. Are these a harbinger of less "borderline" cuts in the future? A way of testing the political waters? It is important that the criteria for deinsuring be explicit and subject to public scrutiny in order to help prevent certain elements within the government, motivated primarily by cost cutting, from making certain procedures accessible only to those who can afford them.▼

— David Haslam, MRG, Hamilton

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becoming an impossible goal with 5 billion people in the world requiring increasingly costly methods of using natural resources to maintain any sort of culture and civilisation, so that funds for social services will remain tight for the foreseeable future. To the physician's responsibilities must therefore be added that the use of the funds available to the greatest benefit of all.

The greatest benefit of all could also not be maintained if we developed a double medical system: public and private. I am therefore strongly opposed to any such development and I would urge all those involved in such decisions not to split our so far quite successful system.

The Globe and Mail noted on 27 April 1992 that nearly half of health care funds of Ontario go to hospitals. This brings me to my final point. Hospitals have become big business and behave and have the faults of big business. The top problem of this from my frog's eye view is a bloated administrative structure. In our hospital, for example, we have two parallel systems of authority in each department and on each floor: a medical and an administrative one. Where we had a hospital administrator, we now have a President. Where we had a chief accountant, we now have a Vice President. The cost of this has become large. I would urge the Joint Committee to analyze this situation specifically. There could well be significant cost saving possible, though I realize that even General Motors has not been able to deal with this successfully.

— Dr. J.V. Frei

MRG responds to proposals to re-direct long-term care

Health Minister Frances Lankin, Social Services Minister Marion Boyd, and the Minister responsible for Seniors' Issues, Elaine Ziemba, have recently issued a consultation paper declaring their intention to redirect and restructure the system responsible for responding to the needs of Ontario's elderly and people with physical disabilities. In response to this policy initiative, the United Senior Citizens of Ontario, the Coalition of Senior Citizens' Organizations and the Consumers' Association of Canada (Ontario) combined their resources into "The Senior Citizens' Consumers Alliance for Long-Term Care Reform".

The mandate of the Senior Citizen's Consumer Alliance is to conduct public hearings to let provincial organizations of consumer and provider groups voice their opinions about the directions that reform of long-term care should take. These hearings ran from February 23 to March 13 and the MRG made its presentation on March 9. Joel Lexchin appeared on behalf of the MRG and focussed on the reasons for the increase in the costs of the Ontario Drug Benefit Program.

The MRG brief pointed out that most of the increase in the costs of the program were due to two factors. The first is an increase in the intensity of physician prescribing: doctors are prescribing to the elderly more often and writing more prescriptions each time they see an elderly patient. Between 1976 and 1988 the number of prescriptions per year that the elderly received went up from 17.8 to 29. In 1978/79 there were an average of 3.6 prescriptions per visit and by 1988 this figure had risen to 4.4. There is no evidence that patient demand is a major factor in determining the number of prescriptions that doctors write.

The brief analyzed the literature on how well physicians prescribe to the elderly and made the point that there is no evidence that this more intensive prescribing has made any difference in the health of the elderly.

The second major factor is that doctors are prescribing newer, more expensive medications in place of older, less expensive drugs. For instance, the average daily treatment costs for antihypertensive products available before

1982 (primarily diuretics and beta blockers) was $0.72, while for drugs introduced since 1982 the cost is $1.15, a 60 per cent increase. However, none of these newer drugs such as the ACE inhibitors or the calcium channel blockers have been shown to reduce long-term morbidity and mortality associated with hypertension. The MRG brief also analyzed the newer antiinflammatory and ulcer medications and pointed out that while they were more expensive than older products they were, in general, no more effective.

The brief focussed on the role of drug company promotion as one of the major reasons why physicians were using these newer drugs and cited a number of studies which have shown that the more heavily a drug is promoted the more it is prescribed. In the year to December 1987, newly introduced products occupied 10 out of 12 spots in the list of the most intensively advertised drugs in Canada.

The brief then went on the consider ways of controlling the cost of the Drug Benefit Program. It showed that user fees or copayments would reduce the use of both medically necessary and medically unnecessary drugs and that there could be a significant deterioration in the health of people. Similarly, just removing ineffective, or less effective drugs from the formulary would not necessarily work either. When drugs are delisted, doctors tend to switch to products that are still covered but which may be no more efficacious than the previously used drugs.

The brief concluded by calling for measures that would improve both the quality of the formulary and of physicians' prescribing behaviour:

1. In order to get a product listed on the formulary it should have to show some superiority over existing products. Furthermore, these drugs should be subject to cost-benefit or cost-utility studies to demonstrate that they offer large enough benefits to offset their increased costs.

2. Drugs on the formulary need to be reassessed at regular intervals to ensure that they have retained their cost effective status.

3. There is some limited evidence that shows that physicians who are not paid fee-for-service are better prescribers than those who are. The brief therefore called on the government to encourage the development of alternative payment methods for doctors.

4. Finally the brief strongly advocated that the government and the medical profession commit the resources necessary to develop non-commercial forms of prescribing information for doctors. In particular, the brief called for the creation of a force of "academic detailers" who would visit doctors in their offices and offer educational advice about prescribing.▼

— Joel Lexchin

The National Health Service

By Haresh Kirpalani

This article originally appeared in the September 1988 issue (Volu;me 8, #4) of ***Medical Reform.***

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

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

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

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

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

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

19th Century:

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

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

Lloyd George:

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

In addition the Boer War (1899-1902) showed that over 50% of the potential recruits were too ill to be drafted, leading to the School Medical

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Service. Just as in the 'Great War' of 1914:

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

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

"The working class will be expecting a really new world. They will never go back to where they were prior to the war."(11)

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

War The Midwife:

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

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

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

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

There appeared to be much common ground. What was all the brouha about then, when the NHS was "hijacked" to be Labour's "Jewel in the crown", as the election manifesto read of the NHS? Nowadays it is easy to forget what the world looked like at the end of the War. The Russian defense against and subsequent assault on Nazi Germany had inspired many sections of society. Even in the British Army such popular affairs as the Cairo Parliament — a mock Parliament — were symptomatic. The Cairo Parliament was broken up because of "subversion" after resolutions calling for nationalizations, including of banks, were passed overwhelmingly!(25) When the Coalition War Government broke up despite the all-Party agreement on the implementation of reform, an election was held and a caricature of socialist bashing began, even though the policies of nationalisation were acknowledgedly supported by the majority of people in Britain. The Tories and Churchill claimed to recognise only Fascism in the Labour Party. Nothing was more calculated than this inflammatory slander to offset the enormous personal popularity of Winston Churchill.(26) In 1940 George Orwell had said that: "We cannot win the war without introducing Socialism".(27) The aspirations of home coming soldiers, and war weary civilians were channeled into the Labour Party. The paint of a socialist nationalisation had to be applied to an already achieved social consensus.

In view of the battle that seemed to be raging between ideologies, it is not surprising that the BMA themselves were fooled into believing that Socialism was dawning and that they would be made bureaucrats. Some vilified Bevan (Labour Minister for Health) as a 'Hitler' — strong words in 1945. The BMA now reneged on their previous commitment to reform. Progressives have interpreted this to meant that doctors are a hopelessly anti-progressive group. The facts do not support this interpretation, but suggest that even at the stage of confrontation with Bevan, most doctors stood for reform. It was certainly the case that the BMA behaved in a most un-democratic manner, disregarding their own constituents; as they have continued to do at various times since. The basis of my contention is contained in the Questionary of the members taken after the publication of the White Paper, which had a very good response. As Eckstein says: "On every substantive issue there was a clear majority for the scheme, and nearly 40% of the profession were for the White Paper, lock stock and barrel. The results of the Questionary must be interpreted as a repudiation of the BMA leadership the profession approved a free service by a vote of 60 to 37% the profession approved a Central Medical Board to be established with powers to keep doctors out of relatively over-doctored areas by a vote of 57 to 39%. The rank and file approved the idea of group practice in health centers by 68 to 24% the abolition of the sale of practices was approved by a large majority."(28) The bulk of the physicians however baulked at the concept of "State Salaried serice"(29). Doubtless their memories of the Poor

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

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

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

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

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

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Steering Committee Activities

The following summary of Medical Reform Group Steering Committee and working group activities covers the period October 1991 to April 1992.

Ministry contacts

Members of the Steering Committee have had meetings with Health Minister Frances Lankin (this meeting was reported in the December issue of ***Medical Reform***) and with Ms Lankin's Executive Assistant Sue Colley. The Steering Committee prepared responses to several Ministry policy statements, including the Consent to Treatment Act, the Regulated Health Professions Act, and the ratification of the OMA contract (see April 1992 newsletter).

Sexual abuse by physicians

Jim Sugiyama wrote a letter on behalf of the Steering Committee endorsing recommendations before the College regarding sexual abuse by physicians.

Health cards

Several instances were reported recently regarding instances in which individuals without health cards were denied treatment or were billed directly for treatment. Among those affected have been infants and the children of immigrants without landed status.

De-listing procedures

A proposal circulating within the Ministry that certain procedures no longer be covered by OHIP was discussed at length by the Steering Committee and the Hamilton chapter of the MRG. Several comments on this question appear elsewhere in this issue of ***Medical Reform.***

Canadian Health Coalition

The MRG has continued to support the work of the Canadian Health Coalition in its campaign to preserve medicare. Frances Kilbertus has been active as the MRG's representative on the CHC Board of Directors.

CUPE Campaign

It was agreed to endorse the activities of the Coalition to Keep Medicare Healthy, which is sponsored by the Canadian Union of Public Employees (CUPE) and by a number of other organizations. The initial phase of the campaign is educational. It urges that alternatives to "the fee-for-service treadmill" be found, that non-physician staff be given a larger role in patient care, that health care for profit be eliminated, and that hospital boards be democratically elected.

Ontario Health Coalition

Members of the MRG have played an active role in re-establishing the Ontario Health Coalition and in drafting its statement of principles (printed elsewhere in this newsletter).

Speaking in the U.S.

Requests have continued to come in for MRGers to speak in the U.S. in support of the campaign for a U.S. medicare system. Future venues include Pittsburgh (meeting of Health Care for All coalition) and Bel Air, Florida (union convention).

Regulated Health Professions

Don Woodside and Rosana Pellizzari attended a Ministry-sponsored meeting on the implementation of the Regulated Health Professions Act.

Hamilton chapter

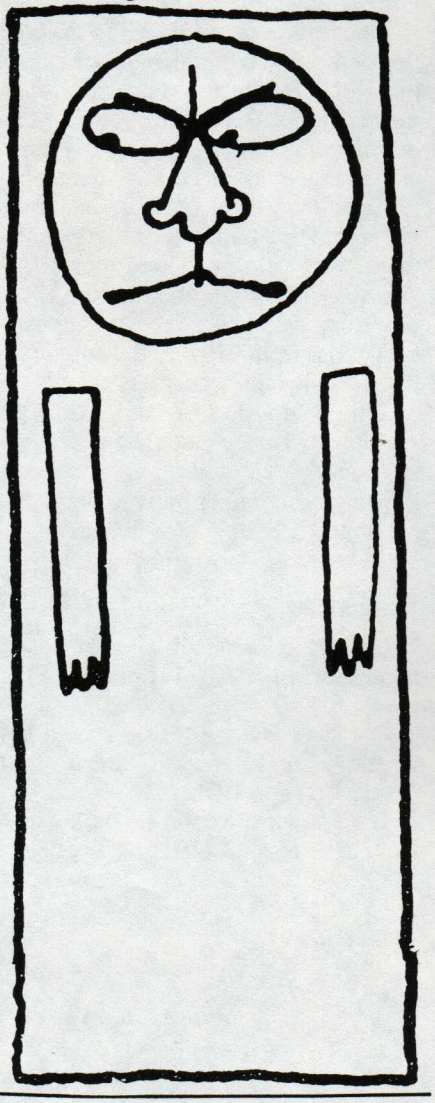
The Hamilton chapter has held a number of meetings this fall and winter.

Proposal for advisory group

The Resource Allocation Group and the Steering Committee have proposed to the Minister of Health that an Advisory Council on Resource Allocation (ACRA) be formed within the Ministry of Health. (This proposal was originally contained in the Resource Allocation paper which appeared in the December 1991 issue of ***Medical Reform.***) This body would provide information and current research on resource allocation questions to the Ministry, specifically addressing issues immediately in front of the decision makers. A number of questions remain about whether and how this proposal should be pursued by the MRG, including questions about what kind of relationship MRG members would like to see between themselves and the government.

According to the proposal, the purpose of the ACRA would be to provide unbiased summaries of scientific evidence, expert advice, and practical guidelines regarding decisions that are of immediate concern. The ACRA would also be responsible for developing common standards regarding the availability of services across the province. Another function would be to educate District Health Councils regarding the appropriate use of scientific information in decision-making. In proposing this function, it is noted that "while it is desirable for decisions regarding the allocation of health care resources to be made by representative groups at a local level, standards regarding the availability of essential services are needed to avoid social injustices that might otherwise occur as a result of decisions being made on an ad hoc basis in an environment in which cost constraint has become a dominant concern.

It is proposed that the ACRA be composed of consumer and provider representatives in addition to people with methodological skills.▼



Medical care in the USA: A case of terminal disease

By Haresh Kirpalani and Gordon Guyatt

INTRODUCTION

The high cost of health care in the USA has fuelled urgent talk of reform. These high costs are troublesome not only to the consumer, but also to American business. In the debate concerning health care reform, Canada has been cited, by both proponents and opponents of reform, as an alternative system. As Lee Iacocca has pointedly stated, American business interests consider themselves at a disadvantage relative to Canadian business. This is because they have to bear the cost of health care insurance – inadequate though that might be for workers in the USA – themselves. Canadian business pays only to the extent that they contribute to general income tax from which health care in Canada is paid. It has been estimated that the penalty for American automakers amounts to an additional $500 per car.

The Medical Reform Group believes that the underlying values of the society will be the major determinant of the choices ultimately made. A careful examination of the evidence regarding the effects of alternate funding and health care delivery systems on quality, equity, and efficiency remains crucial for making rational decisions. The key decision to be made is between tinkering with the current American patchwork private system of care, and a major overhaul which will result in a universal single-payer system. The latter is advocated by, among other groups, the Physicians for a National Health Care System.

The following issues are crucial when considering the system of health care to be adopted:

1. Health care services should be of the highest quality.

2. They should be delivered in an equitable fashion to all members of society.

3. They should be delivered as efficiently as possible.

Any private system where access to services is dependent on ability to pay, threatens the goal of equitable delivery of services. Those who favour a private health care administered by private institutions argue that problems with equity can be minimized, and that advantages in quality, and particularly in efficiency, more than compensate for any losses in equity. To substantiate their argument, those favouring remodelling of the current patchwork private system have made many statements about the Canadian – and other universal – systems. We will present data which demonstrates these statements to be, at best, distortions.

Perhaps the most notorious distortion is the contention that universal-access systems of care have failed. One such system is the British. We will begin by dealing with the issue of medicine in U.K.

The problem of the UK

Great Britain has adopted a peculiar mix of policies. The pressures responsible for this include the same features encountered in other countries, of course combined in a unique mix. The combination of a crumbling patchwork system, coupled with militant pressure from the population worked towards a State system. Resistance from the most reactionary of the medical profession and the private companies worked both to delay the inevitable, and to allow some flaws that would later prove fatal. But the importance of history here is that militant pressure from below was crucial in forcing the change.

Britain is often painted as having chosen a "socialistic" approach. But Britain never enacted legislation forbidding competing private health insurance plans for publicly insured services. In addition, Britain never prevented physicians from continuing with private practices outside of the National Health Service, and from charging whatever they liked to patients seen in these private practices. In practice this never led to problems of access to quality of care while the system was relatively well funded. A very small minority of the population ever sought out private advice.

But the Thatcher government's extreme tight-fistedness with respect to the National Health Service has been responsible for a resurgence of private medicine in Great Britain. The financial starvation of the National Health Service was geared to have this effect. Indeed the private medical companies jumped into the developing breaches in a disintegrating health care system. As the managing director of Medical International said of the openings in the UK: "There is more profit to be made out of health than in selling Kentucky Fried Chicken"[1].

Thus, while advocates of private medicine point to Britain's problems as an example of the detrimental effect of "socialized" medicine, an alternative interpretation is much more likely. We argue that we are seeing the effect of a system in which medicine is not "socialized" enough. If on top of an ill funded system, one allows physicians to charge whatever they like to private patients; and if one allows private insurance for publicly insured services; the public system will be emasculated. The quality of services then declines, and the well off will turn to private alternatives. The result is a two-tiered system of medical care in which the poor receive inferior quality care.

In this context, proposals for the reform of the system in the USA that involve merely expansion of the public without eliminating the private, involve a similar "fatal flaw". There are other reasons why they are unlikely to help in the long term (see below). Turning to the direct comparison between Canada and the United States there are some obvious differences. Canada has consistently opted for a system in which private enterprise is minimized and public control maximized; the United States has consistently chosen a system with a much larger role for the private sector, and much less influence for the government.

Some of the historical features that allows this can be briefly outlined.

History

In effect, a natural experiment has occurred in North America. Two large and wealthy countries, the United States and Canada, exist side by side. Although

the United States is in population much larger, the two countries are similar in their cultural heritage, wealth, and the aspirations of the populace. They have gone two quite different ways with respect to administering their health care systems.

Canada has opted for what is essentially a government run system. The provincial governments administer the health plan, are responsible for the hospitals, and are the sole insurers. People pay for their health care through general taxation and, in some provinces health premiums. Health care is free for the sick; the cost of health care is shared by the whole population. There are virtually no charges at the point of delivery of services. Seeing a physician and being admitted to hospital entails no payment of extra fees.

In the United States, in contrast, the government role is restricted to being the third party payer for some of the indigent and for a proportion of the costs of those over 65. Private health insurance is big business, and a large proportion of the hospitals are privately owned. Patients pay a substantial proportion of their medical costs as out-of-pocket expenses, or through private health insurance.

If the free-enterprise dogma regarding the greater efficiency of a privately run health care system were true, the following predictions would also be true:

First, given the unwieldy bureaucracy that runs the system, administrative costs of health care would be higher in Canada.

Secondly, private for-profit hospitals would run more efficiently than their public counterparts.

Finally, given all the incentives to be efficient and avoid going for unnecessary care, the American medical system would be less expensive. Is this the case?

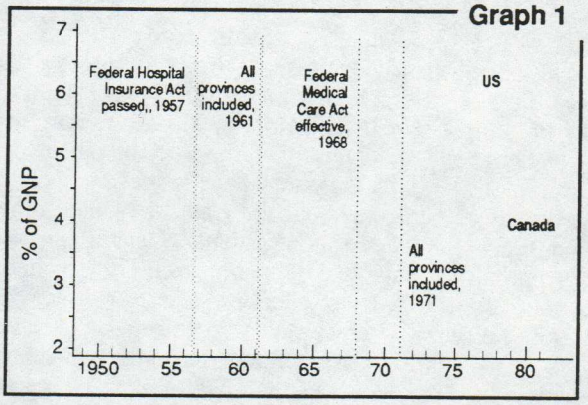
An overall comparison of health care in Canada and the U.S.A.

The immediate answer is no. To demonstrate this, let us examine total health care costs in Canada versus the United States.

In the early 1960s, before the introduction of nationwide universal health insurance in Canada, the proportion of the gross national product devoted to health care was the same in both countries. Since then however, health costs have accelerated at a considerably greater rate in the United States than they have in Canada. Presently, just over 8% of Canada's gross national product is spent on health, where the comparable figure in the United States is almost 11% The difference is even greater when one considers that the per capita GNP is larger in the U.S. than in Canada. (See graph 1 below from Barer et Evans - reference 2).

Graph 1, Hospital and Physician Expenditure as % of GNP, Canada and US; 1948-1983.

Graph 1



The conclusion is inescapable: planning at a provincial level has been more effective in controlling health costs than the market forces at play in the United States. The reasons for this difference are detailed below.

Administrative Costs

To begin with, the administrative costs of private and public health insurance plans can be compared. The administrative costs of administering health insurance in Canada constitute 2.5% of total health care costs and only 1.5% of these costs are accounted for by public plans. Similar costs in the United States for private and public plans combined represent 8.3% of total health care costs, and rise to 12% for only private plans[3].

The reduction in costs is not restricted to administration of health insurance, but extends to hospital administration, and even to administrative costs of physicians in private practice. In an estimate that included hospital administration, nursing-home administration, and physicians' overhead, American administrative spending was calculated as consuming 22% of all health care expenditures[4]. These same authors estimated that the comparable figure in Canada is 13.8%.

The case of nursing home administrative costs is interesting. In Canada, nursing home care is reimbursed through payments by private insurance or direct payments by residents: a system similar to that of the United States. The result is that administrative costs are comparable to those in the United States (10.5%) and greater than those in Canada's acute care hospitals[4]. In Britain, where nursing homes are part of the National Health Service, administrative costs are 5.7% of total spending. This suggests that bringing nursing homes within the provincial health service would save appreciably on administrative expenses.

These results are not surprising when one examines the administrative systems. In Canada there are a total of 10 administrative bodies – one in each province. These are charged with all the paperwork associated with health insurance in the province – and that is their sole responsibility. In the United States there are literally hundreds of insurers. Thus, one disadvantage for the USA system is that economies of scale are lost. The disadvantage for the US consumer is a bewildering confusion of clauses and rules. This was demonstrated in an issue of the *Consumer Report* of the Consumers' Union[5].

There are, however, other major disadvantages of the American approach. In addition to administering health insurance the insurers have another job – getting as much business as possible. This requires advertising, and hiring sales people – an expensive proposition. In addition, they have to compete for senior executives who command extremely high salaries.

The waste of the American system extends into the hospitals. American hospitals require a sophisticated billing department with an extensive internal accounting structure that is necessary to attribute all costs and charges to individual patients and physicians. This is unnecessary in Canadian hospitals. In addition, physician billing is simplified by universal health insurance, reducing the overhead of individual physicians.

When one considers all these factors together, it is no wonder public programs are so much cheaper to administer. The American system forces higher American administrative costs to ensure that those who cannot pay don't get the same access to services as those who can pay. Thus the American ad-

ministrative costs are spent enforcing the restrictions that limit access to health care by the poor.

Public versus private hospitals

Those who believe in the private patchwork health system argue that for-profit hospitals must be more efficient because they have the appropriate incentives to be responsive to market forces. Although there are no data directly comparing Canadian and American institutions, there are data examining public and private hospitals in the U.S. Information is available from a number of studies; the results are consistent and convincing. We shall briefly review three representative studies.

In the first study, 53 investor-owned hospitals in California, Florida, and Texas were compared with 53 closely matched nonprofit hospitals in the same states[6]. Total operating expenses per admission were 4% higher in the investor-owned hospitals, which nevertheless managed to generate a greater net income by virtue of their higher charges.

A second source of information is data from the Florida Hospital Cost Containment Board comparing all proprietary and not-for-profit hospitals in that state for the years 1980 and 1981[7]. Again, the private hospitals had operating expenses that were 4% higher.

A third study examined voluntary non-profit hospitals, public hospitals, and investor-owned chain and independent hospitals in California[8]. Total operating expenses per admission were 2% higher in the investor-owned chains than in the voluntary hospitals. Interestingly, this study demonstrated that one problem for the for-profit chains was administrative costs, which included each hospital's share of the costs of corporate headquarters. In addition, the for-profits conducted more tests and used more supplies per admission as well as charging a higher price per test or unit supply.

These figures are an underestimate of the differences because of a cynical strategy used by private hospitals to improve profits. There are groups of patients, generally the sicker and more complicated, who are more expensive to take care of, and who thus threaten the profit margin. Private hospitals have often been successful in shunting such patients to the public system. This is called "dumping" and has been shown to result in deaths[9]. This process, while making the private hospitals, in isolation, look better, increases transportation costs and therefore actually makes the total system – i.e. private and non-profit together – more costly.

The success of investor-owned hospitals in the United States has been a function of their marketing of services and manipulation of prices and NOT their ability to control costs. Not-for-profit hospitals are actually more efficient and less costly than their for-profit counterparts.

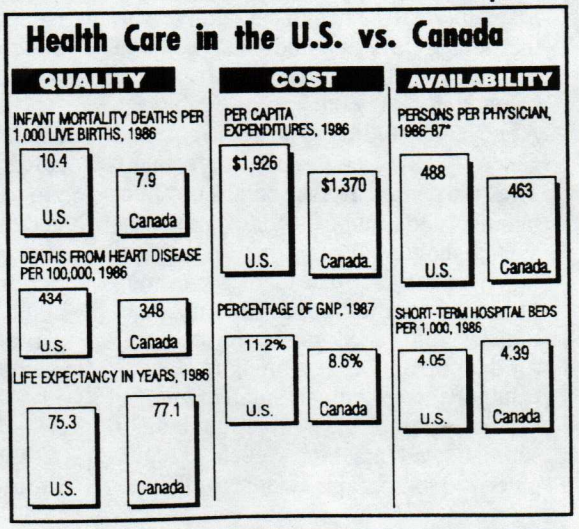
Up to now, we have focused primarily on the issue of cost. The private system is unlikely to provide advantages in terms of quality. Since at the same time it undermines equity, and if costs are equal or greater than public funding – the private option need be given no further consideration. However, it is worthwhile looking at the quality issue.

Is health care quality better in the USA than in Canada?

Could it be that American health costs are higher because the Americans deliver higher quality health cares? The answer is no.

Despite the lower expenditures on health care, all the conventional indices of health, including life expectancy and infant mortality, are actually better in Canada than in the U.S.[10]. To provide specific numbers: life span in 1986 was 77.1 years in Canada versus 75.3 years in the United States; infant mortality was 7.9 deaths per thousand live births in Canada versus 10.4 deaths per 1,000 births in the United States (See Graph 2 below from CCAW Manual Reference 10).

Graph 2



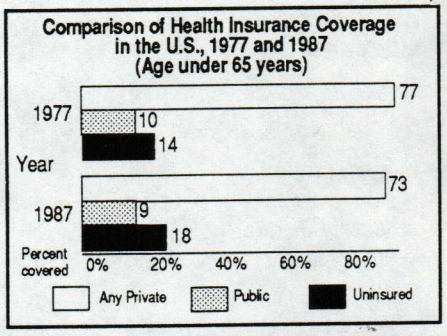
Further, it is worth noting that before the introduction of universal free access to care in Canada and Great Britain, both countries had age-adjusted mortality rates that were higher than those in the United States. Within a decade of the introduction of free access, a sharp decline in mortality occurred, so that the levels in both Canada and Great Britain are now lower than in the United States[4].

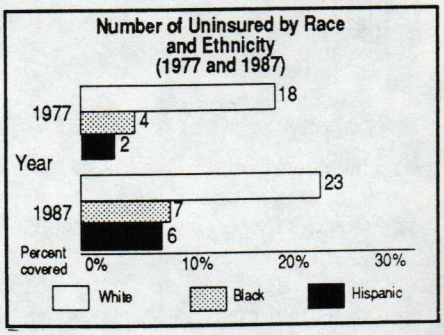
Access to care

A final irony of the relative administrative costs of Canada and the Untied States has been pointed out by Himmelstein and Woolhandler[4]. Overall, health status is better in Canada than in the United States, and this is not surprising when one considers that the barriers to high quality health care for the poor (who have higher morbidity and mortality than do the more affluent) are far more formidable in the United States than in Canada.

What is worse, these barriers, as measured by the numbers of the population that are not covered by health insurance in the USA is, as Graph 3 below shows, actually growing[11].

Graph 3





The burden of costs on the elderly affects all races. This acts as a major barrier to care and is rising rapidly, as the accompanying figure from the New York Times details.

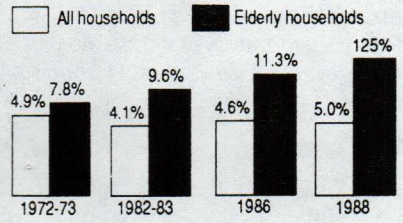
See Graph 4 from New York Times on next page.[12]

From the physician's point of view, an ethical practice of medicine is dif-

Graph 4

A Heavier Burden on the Elderly

Household spending for health as a proportion of after-tax income. Households headed by a person 65 years old or over spend more for health care even as Medicare outlays increase.



ficult, if not impossible, in the American private system of health care delivery. A publicly funded and publicly administered system allows patient needs to remain the sole consideration in physicians' decisions concerning the nature of the services an individual patient should receive. There is no comparable restriction of access to care in Canada.

It is not surprising that the Canadian population is very happy about their health service in contrast to the American population. The following survey statistics make this point clear[13].

Proportion of Americans Preferring Canadian Health System, 1988 and 1990

	1988	1990
Prefer Canadian system	61%	66%
Income group		
Low income	58%	63%
Middle income	68%	68%
High income	56%	65%
Race		
White	64%	68%
Black	61%	54%
Hispanic	62%	57%

Role of physicians

The American Medical Association has long argued that universal-care systems restrict free choice. They argue that they cannot deliver ethical care under a universal-access system, as the system will constrain costs to the point where legitimate needs cannot be fulfilled.

Fortunately, studies are at hand demonstrating that on the whole physicians in Canada support the universal-access system. Thus the following table comes from a survey of physician satisfaction under the Ontario Health Insurance Plan.

Canadian physicians are on the whole happy with the system and feel that they can deliver quality care. The very few that make the noise as they emigrate to the South are after very big bucks and their gloom about the Canadian system should be discounted.

Will a private - public mix solve the USA health care crisis?

From what we have argued, it is clear that patchwork reform will not solve the American health care crisis. If government health insurance schemes can be extended, access to care will improve. But this will not prevent administrative confusion and waste. The opportunity to radically eliminate the waste in the system by simplifying to a single payer scheme (i.e. the government) will be lost. The ability to perform quality of care assessments will also be compromised where there is no single payer system.

In addition, programs targeted for the disadvantaged are easily attacked in times of financial stringency, as the poor and indigent are not perceived as politically important. Furthermore, simply extending the present government schemes will not address the issue of the under-insured. This includes all those with high co-payment schemes and deductibles who are still spending high amounts (on average 18% of their income) upon medical bills.

Finally, we have pointed out the effects of private-public mixes in both the UK and in Canada. Where there was a loophole for profit to be made out of health care, this distorted the actual delivery of care. To not deal with this in any reform will effectively hostage the future.

Are there no problems in the Canadian system?

Of course Canada is not Utopia. But in comparing the health care delivery to that in the USA, it could be argued that it is close! The problems that exist in Canada have been exploited by the American Medical Association, and generally have been vastly exaggerated. Thus the perennial issue comes up about rationing and waiting lists. It seems forgotten that there are waiting lists in the USA!

There is doubt that there is rationing of health care. However, this does not translate into a poorer health outcome for the population. Rationing in Canada is largely geographical. Small towns, for instance, do not have large numbers of sophisticated machines, such as computerized tomography scanners. This relates to the ability of the Canadian system to plan in a manner which is impossible in the USA. Though planning of the system may be incomplete in Canada, it is certainly far more effective than in the USA. This is primarily due to the absence of the profit motive.

Where restricted service becomes a problem, the government is forced to respond quickly. One recent example concerned the availability of cardiac bypass surgery. After a public outcry about waiting lists for open-heart surgery, additional money was targeted specifically for cardiac surgery facilities. In addition, through a concerted effort that involved government and physicians, guidelines were evolved that allowed those most at medical need, and most likely to respond, to obtain treatment ("Waiting list for surgery cut by third". *Globe and Mail*, 23.3.91). As one cardiac surgeon said about the government response to the problem: "Before we had to off-load a lot of patients.... now we are able to service our entire region, a population of 1.2 million, and it's because the ministry has been putting a substantial amount of money into the expansion of regional services.." Dr. Shragge, Surgeon, Hamilton Civic Hospital. (Cited *Globe and Mail*, 23.3.91)

It is crucial to note that where it is demonstrated that there are defects in the health care system, the population of Canada do not hold back their anger. Canadians feel they have a right to high quality health care.

The future for medical care in Canada

Perhaps the biggest problem for the Canadian system are threats to universal access. These are a result the financial deficits prompted by the international recession. Despite the popularity of the system, politicians have begun to cut back and restrict care.

Ultimately, discussion about being able or unable to afford a societal health care system revolve around notions of a progressive tax system. It has been argued that there is still a lot of room for improvement in this regard in Canada. For instance, at a time of national deficit and talk about cutbacks, the federal government has introduced a tax windfall for the wealthy -Release No. 91-018. This potentially amounts to billions[16].

These are issues that will have to be fought. It is a battle that requires

progressives of all stripes to come together. The Canadian Health Coalition, of which the Medical Reform Group is a part, has recently announced its' vocal opposition to any move to restrict the "jewel in crown of social programs in Canada", the health care system (*Globe and Mail*, 20.12.90)

A successful conclusion for a universal health care single payer system in the USA will help the Canadian advocates of universal care, as well as the American population.

Conclusion

It is clear from the data that the oft-quoted relative efficiency of free market, free enterprise, capitalist methods is a myth when it comes to health care in North America. Universal-access medicine in Canada has produced a superior product, and a healthier populace, at a lower cost, than the free enterprise American system. Further, the quality of health care delivered to the entire populace is better, and the gross inequities of the American system have been avoided. A broad alliance of Americans is fighting for a comprehensive single payer system. If they are successful, health care in America will improve in quality, efficiency, and access.

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Changing the Last Dinosaur: Analyzing the reform of the National Health Service

By Reg Race

This is a shortened version of an article analysing the Health Service reforms brought in by Britain's Conservative government which first appeared in the Autumn 1991 issue of ***Catalyst****.*

The Government's health service reforms, introduced in April 1991, are gathering pace. A new 'contracting culture' has been established in the NHS. The first wave of Hospital Trusts are now operational, with a second wave to be established next April; plans for a third wave are clearly dependent on the result of the next election. Indicative cash-limited drugs budgets have been introduced for all General Practitioners, and larger GP practices are running their own budgets without recourse to local Family Health Service Authorities.

The Conservative Agenda

The agenda set by the Government is almost entirely managerial in character. Under Mrs. Thatcher the reforms began as an attempt to control the expenditure of the NHS without incurring the damaging political backlash that had bedeviled previous Tory attempts to control spending. However, controlling expenditure was not the only objective. Conservatives wanted to inject a wholly new managerial approach to health service planning. This means ridding the NHS of the last vestiges of local accountability and implementing measures that would liberate local managers from the need to refer upwards to higher levels of authority when making decisions on major capital spending and the employment of staff.

In order to make the reforms stick, they had to change the culture of the NHS. They regarded the service as the last dinosaur: impossible to abolish, but desperately in need of remedies which would keep control away from both interfering local councillors and doctors, who were now no longer the reliable stooges for Tory policy that they had been since 1948. The Tories intended that the reforms would enable NHS managers to get closer to their markets – that is, to their patients – and to develop services which would explicitly reflect the needs and aspirations of the local population. A subtle sub-agenda was also in the minds of Ministers. by introducing these reforms they hoped to make the Labour Party and the Trade Unions look as if they were defenders of the status quo – defenders of a system which was arcane, unfair and unreliable.

The Core Reforms

These Conservative aspirations were made operational by five core reforms:

1) The creation of NHS Hospital Trusts with wide-ranging powers which made them independent of both Health Authorities and Government policy;

2) The separation of purchasers and providers in the NHS. This allowed District Health Authorities (DHAs) to concentrate on the definition of service needs and health objectives, whilst local hospitals became the providers of services;

3) The creation of indicative drug budgets, which placed cash limits on the prescribing practices of local doctors;

4) The creation of GP Practice budget holders, with the objective of making the biggest practices independent of outside decision-making.

5) A new relationship with the private sector, with Trusts in particular being able to construct deals with private health care organizations over land and the provisions of services.

There is no doubt that the creation of Hospital Trusts has proved to be popular with health managers. The freedom to pay themselves what they wish, to employ whatever staff they wish, and to negotiate contracts with health authorities for the services they provide has obvious appeal. The new 'contract culture' separating purchasers from providers has been rather less popular overall, and many of the brightest and best managers have moved to provider units rather than stay with the less exciting DHAs,

If these changes continue uninterrupted the NHS will be transformed in five years' time. Most hospitals and many other provider units will have become Trusts, as managers and doctors scramble to become part of the mainstream; the purchasers/provider split will be institutionalized, with an increasing role for the private sector; and national pay bargaining will be destroyed as local agreements made by Trusts supersede national pay raises and conditions of service.

The Big Drawbacks

For the NHS there are major drawbacks to the reforms. The most fundamental is that the increased emphasis on contracting, in pure NHS hospitals as well as in Trusts, means that the administrative costs will rise from around 4 per cent of total budget to a figure of over 10 per cent in five years. These increased costs stem from the need to price all procedures and practices, to establish contracts and thereby to win patients for the unit concerned. As the NHS had never previously priced procedures in this way, costs were not reliably known at the beginning of 1991 and an army of accountants and administrative staff has been set up to estimate costs and run the contracts.

The new pricing regime is accompanied by other pressures which will increase administrative costs. These include the need to introduce billing procedures for all contracts and treatments; the need for additional expenditure on local industrial relations procedures as a consequence of the abandonment of the Whitley system; the need for contract monitoring units at both the purchaser and provider ends; and the need for substantial investment in new technology and support staff to ensure that the corporate systems that provide financial and management information are in place and are producing information on time and at the right quality level.

The inevitable consequences of this increased administrative cost over a

period will be that funds for patient care will be squeezed, with a lower proportion of total expenditure going to direct patient care.

The second major drawback to the reforms in that they create not a free market in health care but an administered market. Increased efficiency (by which we mean the market concept of improving the throughput of patients on ward and the elimination of underused or inefficient capacity will not in itself call forth new resources to meet increased demand for services. This cannot happen because the NHS as a whole is still cash limited by the Treasury, and the DHAs which agree the contracts with the Trusts and NHS hospitals will be cash limited in turn through the application of central government grants to them. The consequence of increased 'efficiency' are likely to be the closure of units that do not compete effectively for patients and increased congestion in the units that remain open. The most striking result of this competition is likely to be felt in London and other inner cities where there are hospitals competing for the same pool of patients.

The nature of Hospital Trusts is also likely to be a long running sore. They can be as secretive as they like and there may be strong public pressure for increased accountability. Furthermore, the purchaser/provider split is fraught with problems. The local authority experience of the Compulsory Competitive Tendering legislation has shown that there are advantages to an authority specifying precisely what it does and what its costs are; but there are key questions for the purchasers. How do they interface with the corporate systems of the provider units? How do they interface with the differing financial systems of those units? How do they get reliable management information on issues about which the provider units are being evasive? In addition, who monitors the GHAs' assessments of the provider units? Community Health Councils are already under-resourced and have few powers in relation to local or national policy. In future they will not be able to gather official information, and answers to questions in respect of policy or individual cases from the provider units. In addition, Trusts and NHS hospitals will be able to deny information to the outside world in the grounds that it is commercially confidential.

The fact is that the DHA's are monopoly purchasers in an administered market that is cash limited. Real price competition cannot exist in such a market, and it is impossible to establish reliable prices for community services and health prevention measures.

The most serious long term effects of the reforms, however, is the change the basis of provision from need to price, and to make this the explicit basis of health allocation. This change in the culture is the most important aspect of the Tory reforms; and the change in culture is buttressed by the way in which the private sector is enabled to grow through the use of public funds. For the first time in NHS history, taxpayers' money is to be used, via GP practice budgets, DHA contracts with private hospitals, and Trust arrangements with the private sector, to enhance the size and weight of the private sector relative to that of the NHS. A calculation has been made by Tory Ministers that the British love affair with the NHS means that the private sector was doomed to play second fiddle to it for decades to come; the new arrangements are meant to intertwine the interests of the private sector with the public sector to such an extent that public provision cannot be reasserted without disproportionate cost to the exchequer.

The effects on patient care are likely to be severe. The frail and elderly, particularly in rural areas, may have to travel long distances in order to obtain treatment at a hospital that has a contract with their Health Authority; and there is already evidence of GPs striking off patients from their lists because they are too 'expensive' to contain within their cash limited budgets.

Conclusions

There are two kinds of conclusions that the labour and socialist movement should draw from the Tory reforms. The first is that the changes to the NHS do need reversing. They cannot be left in place, because they will fundamentally and rapidly alter the character of the service.

The second kind of conclusion is more fundamental. The whole reform packager is about the structure and processes of a national sickness service. It does nothing to promote more balanced expenditure between health promotion and prevention, and the needs of the acute and community sectors of the NHS. The labour and socialist movement must ensure that proper prominence is given to the urgent need for a new health promotion strategy which is capable, over a decide, of changing the public attitudes, commercial interests, and government policies which conspire together to give us the most lethal diet in the world, the worst rates of heart disease in the Western World, and appalling levels of strokes and cancers. The challenge for the Left in Britain is to regard these factors as the core problems which the new health agenda for the 90's must be constructed. It is clear that any rational approach to policy must concentrate on the budgets and policies relating to the housing stock, poverty and incomes as well as to the policies and practices of the NHS. Such a new agenda must include a radical democratization of the NHS and measures which will enable the service to assess the real needs of patients and the wider population. The Conservatives have proved that they re indeed a party of radical reform in the interests of marketization: socialists must now ensure that we are not caught flat-footed as the defenders of an inadequate and outdated moral and administrative order.

Dr. Reg Race was a Labour MP until 1983. He is now a consultant working in local government and with national health charities.

Documents and Publications Available

The Medical Reform Group has produced a number of briefs, position papers, analyses and other documents. These publications are available at the following prices:

MRG History and Policies.....$2

Constitution of the MRG $2

Brief on Canada Health Act $2

Submissions on Ontario Health Professions Legislation (1987-9) $2

Maternal Health Care $4

Complete Edition of MRG Newsletters, 1979-1991 .....$35

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Medicare on the line: MRG Spring meetings look at the future of health care

What does the British experience tell us about the future of medicare here in Canada?

What future does medicare have here in Canada?

The Medical Reform Group of Ontario is holding two meetings this May to look at these questions.

On Tuesday May 19, featured speaker Gavin Mooney of the University of Aberdeen in Scotland will be speaking about the British National Health Service.

On Thursday May 28, members of the Ontario Health Coalition and the Medical Reform Group will look at what the future holds for medicare in Ontario and what can be done about it.

The May 19 meeting will take place at 8 p.m. in the Debates Room of Hart House at the University of Toronto.

The May 28 meeting will take place in the chapel of St. Paul's Centre at Trinity, 427 Bloor Street West in Toronto (one block west of Spadina Avenue). The meeting on medicare will begin at 8 p.m.; it will be preceded by a business meeting of the Medical Reform Group beginning at 6:30 p.m.

For more information, contact (416) 588-9167.