MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

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Primary care alternatives scrutinized

In conjunction with the Ontario Chapter of the College of Family Physicians and the Association of Ontario Health Centres, the MRG held a forum on alternative models of primary care on November 18. Speakers at the forum, held as part of the annual meeting, included John Forster, Tim Kerr, Rosana Pellizzari, and Michael Rachlis.

Dr. Forster described a recent proposal which he co-authored with Dr. Walt Rosser, on reform of primary care. In large part inspired by the British system of primary care delivery, Dr. Forster painted a picture of a capitation-based system with patients registered with primary care practitioners, regional monitoring, and a system of setting health goals and implementing programs to achieve these goals.

Dr. Kerr, who has served on a number of important committees with the College of Family Physicians and the OMA, took a more conservative approach. He described how much of his last 15 years have been devoted to getting a better deal for primary care physicians within the OMA, and how his success has been limited. He sees the setting of individual caps as a retrogressive step. At the same time, he continues to support fee-for-service as a major, if not the primary, mode of physician reimbursement.

Rosana Pellizzari, a member of the MRG steering committee, spoke as a representative of the Ontario Association of Health Centres. Rosana was the president of the organization from 1991 to 1993 and continues to serve on the executive committee. Rosana's vision of reform was based on the Alma Ata definition of primary health care. She reviewed the history of community health centres and described their functions including the important role of community involvement and the role of nurse practitioners and other health personnel. She reviewed the report of the Strategic Planning and Evaluation Project, including a review of the current literature which highlighted the dearth of health delivery research and the major potential deleterious effect of both the social contract negotiations and the Joint Management Committee.

Michael Rachlis is an MRG member and a widely respected and oft-quoted health policy analyst. Michael emphasized the potentially devastating effect on primary care physicians of the OMA's way of dealing with social contract issues. He expressed his intense disappointment with the Rae government's refusal to consider fundamental restructuring of primary health care delivery. He painted a bleak picture of the future, and suggested the only hope might be if a group of primary care physicians decided to negotiate with the government as a bargaining unit separate from the OMA.

Approximately 40 people attended the seminar and engaged in a lively debate. The focus seemed to be on methods of physicians reimbursement, at the expense of consideration of other issues in health care reform. The positive recent experience of primary care physicians in Britain was highlighted. There seemed a consensus that current directions are potentially disastrous, but neither the Ontario government nor the OMA has the political will to tackle the absolutely

Continued on Page 2

INSIDE

Practice guidelines discussed

The Medical Reform Group's fall general meeting, held November 4 at the Davenport-Perth Community Health Centre in Toronto, was devoted to the topic of practice guidelines.

Ian Scott introduced the evening's guest speaker, David Naylor, head of the Institute for Clinical Evaluative Studies.

Naylor began by noting that while methodologists are making inroads, the evidence for a lot of what we do in medicine in weak. We base what we do as physicians on some combination of evidence, inference, experience, and opinion.

The type of evidence we have, and its value, varies greatly. Not all studies are created equal; they range from rigorous randomized trials to studies with weak designs to anecdotal evidence. Every trial is in fact only an estimate of effects. Yet we are always creating chains of evidence built on sand castles.

We need not only studies, but studies of studies. In fact, multiple trials and meta-analyses of studies are now becoming more common.

Naylor pointed to the importance of being clear about just what the evidence *means*, and being very cautious about the conclusions we draw from it. For example, evidence shows that aggressively intervening to lower cholesterol may indeed reduce coronary deaths to some degree. But what has been less noted is that these gains are accompanied by increased mortality due to other causes, as well as quality of life problems.

Nor can we assume that it is possible to generalize to real life from the results of a particular study done under particular controlled conditions. Some studies allow all sorts of "slippage". Other studies are so rigorous that the criteria for

Continued on Page 2

Practice Guidelines Scrutinized
Continued from Page One

participation exclude 99% of the population.

How much can we generalize from a trial involving carefully pre-selected, highly motivated individuals supervised by a whole team of health professionals in a rigorously controlled clinical setting with access to resources rarely if ever available in day-to-day settings?

We should always be asking how the conditions of a trial could be translated into real life. *Can* they be applied? Guidelines for clinical trials should also, and especially, have to explain how you're going to inform and involve patients.

Very few studies have long-term follow-up so we project like crazy to get the life-years gained.

It is often not rational to maximize utility in guidelines. If you fall outside the utility guidelines, you don't get the technology or treatment even though you may value the outcome.

And how are you going to enforce and involve physicians? Physicians need sound bites, not long algorithms.

The best predictor of a guideline being followed is previous practising of the behaviour recommended. How you use guidelines to *change* behaviour is another matter entirely.

We often lose sight of the needs of practitioners and patients alike.

In all our focus on design of clinical trials, we've ignored outcomes and how people value outcomes and how you present outcomes.

It isn't enough to develop guidelines. You have to figure out why you are developing guidelines and what the criteria are for what makes a good guideline. For example, are you trying to improve outcomes, save money, improve access? Are the guidelines acceptable? Implementable? Practical?

We need to test guidelines in the field in the same way we field test drugs and devices.

Getting physicians to follow guidelines requires audit and feedback, Continuing Medical Education, using local opinion leaders, peer pressure, etc.

You need adequate representation of the user group on the body setting the guideline.

It always boils down to: How are you going to get down to the local level?

After disseminating a guideline, you have to see if the guideline did what it was supposed to do.

Addressing himself to the question of whether we should stop paying for treatments and procedures that aren't appropriate, David Naylor argued that it is very hard to decide what was appropriate and what wasn't from an OHIP claim card. Procedures which are inappropriate for one patient or set of circumstances may be appropriate for another patient in another set of circumstances.

While guidelines can help give direction, enforcement of guidelines within a fee-for-service structure is very difficult. It is more sensible to look at alternate forms of payment. Removing the financial incentive to perform unnecessary procedures has a certain effect on how often the procedure is performed unnecessarily.

Nevertheless, fee-for-service will be with us for a long time, so it is necessary to find some ways of changing physician behaviour within the fee-for-service system.

Physicians who have totally abnormal patterns of practice will be spotted by practice screening at the OHIP billing level.

CME will play a continuing role.

As drug companies are well aware, 80 per cent of prescriptions are written by 20% of physicians. Targeting their prescribing practices will have an important effect on the system overall, if it can be done successfully.

David Naylor left after his presentation, and Ian Scott introduced the topic of the recent measures in British Columbia. The B.C. government has announced that health plan coverage will be limited to "necessary" procedures and tests. Procedures which are considered not to be medically necessary will have to be paid for directly by the patient.

Jason Barton asked how this is going to be implemented. How do they get to decide if it was medically necessary or not?

Michael Rachlis said that they are now discussing how to implement this. For example, the physician might have to tick off on a form showing which risk factors made a test necessary for a particular patient. Michael noted that there will be pressure to allow more and more private spending. It is simultaneously a way for government to reduce its expenses and for physicians to maintain or increase their incomes. This is effectively an alliance between government and physicians against patients. The whole issue would be much less of a concern in a non-fee-for-service setting.

Gord reported that the Steering Committee had discussed this issue and taken the position that this shouldn't be done on the backs of patients. If it is necessary, it should be paid for; if it isn't, it

Continued on Page 3

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 158, Station D, Toronto M6P 3J8. Phone: (416) 588-9167 Fax: (416) 588-3765.

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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.

Primary Care Alternatives...
Continued from Page One

necessary step of restructuring. However, it was clear that alternative models, including the capitation/community health centre model that the MRG advocates, have been sufficiently well-developed that they are likely to play a more prominent role in the debate as the situation continues to deteriorate.▼

Gord Guyatt

Marcel Massé was right the first time

Canada spends more than 9 per cent of Gross Domestic Product on health care. The United Kingdom spends less than 7 per cent. If we could reduce our expenditure to the British level, we could be making a significant impact on our deficits.

This observation was made publicly by the new federal Intergovernmental Affairs Minister Marcel Massé. Within a day he was being criticised by Finance Minister Paul Martin and Dr. High Scully, a Toronto cardiac surgeon speaking on behalf of the Canadian Medical Association.

Not only was Massé correct in making the assertion, but he also correctly stated that Britain provides services that are "at least comparable" with Canada's. It does indeed and unlike Canada it has universal primary care registration, nationally established health care objectives and a sophisticated system of accountability. All these advantages are vital for the proper management of a national health care system. The cost disadvantage of Canada is even more striking in view of the significantly under-serviced areas in all parts of the country; higher expenditures can even give rise to a less effective system if not properly organized.

Even while waiting for the federal government to get its act together, Ontario can start to move to make these changes happen and reduce its deficit through health reform. As I have been pointing out in the Public Accounts Committee of the Legislature, we have the opportunity to replace the expensive and ineffective Health Cards with universal registration. Despite Dr. Scully's claims, reforms in the U.K. are popular with both patients and doctors.

Too bad that Mr. Massé was right the first time and that misunderstanding of the exciting potential of health reform forced him to act like an old style politician and backtrack.▼

Bob Frankford

Bob Frankford is a physician and the MPP for Scarborough-East.

Practice Guidelines Scrutinized
Continued from Page Two

shouldn't be available whether the patient is willing to pay or not.

Don Woodside said that he did not feel comfortable with saying that things are not available if they are not medically necessary. What if you want something which is not medically necessary but which is important to you, like plastic surgery? Are we saying plastic surgery should not be available? How about in-vitro fertilization? Don said that he would support banning private *insurance*, but there is a role for some things that are not medically necessary to be available on a patient-pay basis.

There was agreement that Don's dilemma is a real one for which there are no easy answers.

Mimi asked how do you deal with situations where consumers demand and expect a particular test. Denying someone a test which the patient wants but which the guidelines say is unnecessary can create a high level of anxiety which can be unbelievably hard to alleviate.

Ty Turner said that this is a consumer society in which many things are consumer-driven, not just physician-driven. It is hard to turn back consumer demand with medical guidelines. He also suggested that with the recent changes in the health care system, the JMC, etc., fee-for-service is now much less likely to disappear. The government has been flooded with requests from physicians wanting to be placed on alternate payment mechanisms, but it has stopped accepting them. Governments are finding ways of cutting costs *within* the fee-for-service system, and as they do so they are less inclined to consider alternatives.

Debby Copes said that a lot of services are useful in some situations but the problem is that they are too widely used, in situations where they are not appropriate.

Jason Barton said that the United States, through the insurance plans, now has incredible micro-management of physicians and what they may or may not do. Are we going to get the same thing in Canada, under the guise of guidelines?

Gord Guyatt said that individual discretion always has to play a part. However, the solution to the problems and dilemmas being expressed is ***not*** "if you want it, you pay for it."

Michael Roberts said that cost is not the only issue. Appropriateness is also a concern.

Michael Rachlis said that if physicians are allowed to provide some marginal services outside the health care system, then there should at least be an accurate actuarial analysis to see what the private procedures are costing the public system. In nearly all instances, infrastructure and other costs of private services are actually paid for by the public, but this is not usually identified. He could live with some medically unnecessary services being outside the system if the fee paid covered all the costs to the public.

Michael Rachlis said that the British Columbia agreement gives the British Columbia Medical Association the right to veto money going out of the fee-for-service envelope to alternate payment. He said the low-volume fee-for-service doctors are being screwed by the latest agreement in Ontario. He said that he wouldn't be surprised to see pressure coming from family practitioners to have non-fee-for service payment mechanisms.

Debby Copes said that we agree that optimally public money shouldn't be going to pay for useless procedures. The question is, how to do it without causing all sorts of other problems?

With that, this part of the discussion wrapped up.

Rosana Pellizzari said that there are three vacancies on the Steering Committee. She noted that the Steering Committee meets monthly, and that being on the Steering Committee is extremely interesting and rewarding.

After this portion of the meeting, the lights were turned low, and people settled down in the warm glow of the flickering screen to watch the film *Doctor to Doctor: Canadian Doctors Describe Their Health Care System.* The film, by U.S. filmmaker Robert Purdy, features a number of MRG members.▼

Oops!

The by-line for the article "Bitter harvest in Vietnam" in the November 1993 *Medical Reform*, was inadvertently omitted. The author was Nicholas Cumming-Bruce.

Bill 50: Tinkering with the non-system

The Medical Reform Group Steering Committee submitted the following brief on Bill 50: An Act to Implement the Government's Expenditure Control Plan, to the Ontario Legislature's Standing Committee on Social Development, on November 12, 1993.

Introduction

The Medical Reform Group of Ontario is a voluntary organization of 200 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: Health Care is a Right; Health is Political and Social in Nature; and The Institutions of the Health System should be Democratized (re-structured in a manner in which equally valuable contributions of all health care workers are recognised and decisions are democratized).

The Medical Reform Group (MRG) has repeatedly called on provincial governments to reform the delivery of primary health care. We support structures of payment and primary care provision which recognise and address the social and economic roots of ill health, which are based on **rational planning, accountability, and monitoring and assessment of results**, which give a greater role to non-physicians, and which favour **capitation and salary** as payment mechanisms. Over the past fifteen years, the MRG has encouraged and supported the establishment of non fee-for-service payment mechanisms, but always in the context that their introduction would be followed by evaluation in a public forum with the view to long-term health reform.

While we support the overall provincial initiatives to reform health care, our criticisms of both the context and the content of Bill 50 are based on our disappointment that the Bill only tinkers with the existing non-system, leaving the major flaws intact.

SECTION 5

Section 5 repeals Section 45 of the Health Insurance Act, allowing the delisting of insured services. We have been calling for a **review** of the entire Fee Schedule, within the context of a health care system where Primary Care providers are salaried or capitated. Thus, the Fee Schedule would apply only to specialists, laboratories or diagnostic imaging facilities.

Such a review would require development of explicit criteria to judge whether a service is medically necessary and should therefore be insured. It would also require open, public consultation with health care workers and consumers.

We agree that the Ministry of Health should have the ability to remove services with no diagnostic or therapeutic value, based on a review of the scientific literature. We are also aware that there are many services, such as cholesterol testing or circumcision, which are medically indicated in only certain circumstances. The development of criteria, with subsequent audit and feedback requires physician "buy-in" and compliance. An effective monitoring system is crucial. We do not promote the model of therapeutic committees, such as the hospital abortion committees of the past, reviewing and passing judgement on each case.

We caution government that delisting of services is simply the first step in major reductions in the range of services that are covered. This is truly an erosion of our **comprehensive** health care system. Delisting can disproportionately affect poor or minority groups. It can encourage the development of two-tiered medicine, where ability to pay determines access to needed services. It can facilitate the shift of physicians, trained with public funds, away from the public system and into the private one, providing delisted services to the wealthy or the privately insured.

When services become delisted, the government forfeits its ability to set the price. We urge you to consider what has happened in cosmetic surgery, where market forces of supply and demand set the price. There is tremendous potential for profit if services are delisted and providers can charge what the market will bear. Within the medical profession, there is significant support for delisting as the opportunity to increase incomes. To quote a Chief of Surgery: "If doctors can set their own fees for these (delisted) services, and in a sense work outside the system, why would they continue to treat trauma patients? This way they make good money and don't have to get up at 2 a.m." (Dr. Girotti, *Ontario Medicine*, September 20, 1993).

In addition to creating a two-tiered system, delisting services and allowing third party payment for uninsured services, such as notes for absenteeism, camp or school physicals, completion of welfare forms or immunization records, allows physicians to offload charges onto individuals and others. We are already aware of excessive charges to patients for services such as transferring of records (e.g. patients being charged $30.00 for a copy of an obstetrical ultrasound report) and are aware of children being prevented from attending school because parents could not afford to pay their doctor $40.00 to complete a Tuberculosis Control form required by public health officials. Is this what we hope to accomplish? The answer seems clear: true health reform should promote and strengthen the health of all Ontarians. The amendments proposed in Bill 50 present a narrowly focused attempt to contain costs and restrict access while maintaining physician incomes.

SECTION 6

Section 6 allows for regulations to stipulate different fees for similar services, dependant on the provider, location or a combination of the above. The OMA has interpreted this section as the legislation necessary for government to pay new doctors differently than more senior ones, specialists differently than general practitioners, doctors setting up practice in over-serviced areas differently than those establishing themselves in under-serviced areas.

The current fee-for-service payment system has contributed to the maldistribution of human, i.e. physician, resources. By capitating general practitioners, and by requiring that all Ontario residents register with a practice, physician distribution will be linked to population distribution. The use of funding envelopes would facilitate needs-based resource planning, and provide more resources to communities where geography or social-demographics necessitate greater or different modalities.

We agree that the government should have greater ability to determine fees in a reformed system, particularly if, as anticipated, the Regulated Health Professionals Act broadens the choice and

Continued on Page 5

De-listing: Flawed process, wrong focus

Presentation to the Joint Panel reviewing proposed changes to the OHIP Schedule of Benefits by Dr. Michael Rachlis

Introduction

I have two major concerns with the Joint Management Committee's (JMC) recommendations to de-list 19 services from the Ontario Health Insurance Plan system of benefits. The first is that the process is procedurally flawed. Second, the Joint Management Committee's de-listing strategy leads attention away from policies which would reduce the cost of medical services **without** reducing needed services.

The Committee's process is procedurally flawed

While the province may decide what health services it wishes to cover through OHIP, the federal government is also directly involved. The Canada Health Act states that the provinces must provide coverage for those services which are "medically required" or "medically necessary". If the province does not cover such services then it is in breach of the Act and the federal government could penalize the province by withholding some or all of the province's grant due under the Established Programs Financing Act (EPF). Unfortunately, neither the federal government nor the provinces have ever developed an operational definition of medical necessity.

As a result, there is chaos across the country on what is deemed medically necessary. For example, the Joint Management Committee has recommended that all Ontario women be covered for invitro fertilization (IVF) but they should be restricted to three cycles of treatment. However, the same week the JMC made this recommendation, the Federal Royal Commission on New Reproductive Technology recommended that IVF be restricted to women whose sole reason for infertility is blocked fallopian tubes but did not recommend any restriction on the number of eligible cycles. To complete the confusion, no other province provides full funding for IVF treatments.

Given the *de facto* involvement of the federal government, the province should not take unilateral steps. If it wishes to pursue the de-listing of benefits (which I do not recommend — see below) then it should do so in very careful consultation with the governments of Canada and the other provinces.

Continued on Page Six

Bill 50 - Tinkering with the non-system
Continued from Page Four

availability of health providers. We caution that it not be the exclusive or even major strategy to solve problems of access or efficiency.

SECTION 7

This amendment gives government the ability to limit services to a specific number within a prescribed amount of time, as in the case of eye exams and psychotherapy. Services exceeding the ceiling could be paid at reduced amounts, or not at all.

At first glance, this amendment appears desirable in that it would allow for the implementation of evidence-based practice guidelines. However, setting predetermined restrictions within a fee-for-service context may only serve to create more bureaucracy and frustration if it forces providers or consumers to complete more paper work and undergo delays in accessing necessary services.

Physicians and other providers, practising outside the context of fee-for-service would not experience a monetary incentive to provide unnecessary services, such as additional eye examinations or superfluous psychotherapy. On the other hand, if a client needed more than average services, there would not be the hassle or delay of seeking exemption, as currently exists with delisted products in the Ontario Drug Benefits formulary.

We would then be able to focus on improving clinical decision making based on scientific research and intellectual debate, rather than pre-determined rates. Strategies such as academic detailing, audit and feedback are probably more effective than the scenario created by Section 7. We know how powerful monetary incentives are, and they could be utilized to promote and reward effective and efficient clinical practice once we have the information systems and outcome measures to facilitate the proper use of clinical guidelines.

SECTION 8

Section 8 grants broad powers to the government to introduce regulations to control expenditures and the supply and distribution of physicians, practitioners and health facilities. The MRG supports informed and democratic resource planning and allocation. We are not surprised that despite years of discussion and a healthy bank account, the medical profession has failed to address this long-standing issue of human resource planning.

The MRG hopes that these amendments will not be ends to themselves, but will facilitate opportunity for population based planning and resource allocation based on reliable indicators of need and effective strategies of demonstrated effectiveness. We support a more accountable system than presently in place, with better monitoring and consistent use of outcome evaluation for decision-making.

CONCLUSION

The Expenditure Control Plan continues to support the present fee-for-service structure of physician payment, which promotes volume and creates incentives for the provision of unnecessary services. The Medical Reform Group supports amendments to the Health Insurance Act which allow for better resource planning and a diversification of providers, such as Nurse-Practitioners, Midwives, Social Workers and others, in a **new model of primary health care delivery** such as is currently present in community health centres and some health service organizations.

By introducing expenditure controls without addressing fundamental reform of the system, we worry that access will be seriously eroded and that both real and perceived barriers and restrictions breed further public discontent and disillusionment with the future of a universal and comprehensive health plan. This would provide existing proponents of privatized, two-tiered medicine, with the fuel to further dismantle Medicare.▼

This brief was written by Steering Committee members Rosana Pellizzari and Vera Tarman.

Delisting - A Flawed Process
Continued from Page Five

To my knowledge, the review committee has not developed any operational criteria for medical necessity. The province has not developed any such criteria. There cannot be due process if there are not such criteria or definitions.

Recommendation #1

The review committee should recommend that the JMC not proceed with de-listing of services from the OHIP schedule of benefits. The review committee should recommend that the JMC and the provincial government approach the control of the costs of medical services through other avenues. If the provincial government and the Ontario Medical Association still wish to pursue the delisting of benefits they should first develop an operational definition of medical necessity and then clarify such a definition with the federal and provincial governments.

There are many ways to save money on medical care without de-listing benefits

The JMC would have us believe that de-listing OHIP services is the main method by which to save money from Ontario's medical care expenditures. Unfortunately almost all medical services are appropriate for some persons at some time. The death of spouse or child might make the reversal of a vasectomy or tubal ligation an appropriate service. Someone might acquire a disfiguring tattoo during a period of drug addiction. Removal of the tattoo could be an appropriate part of that person's overall rehabilitation.

The JMC is attempting to focus the province's attention on which patients are 'less deserving' and who should be tossed from the life raft. In fact, there are literally hundreds of ways that medical care could be made more efficient without depriving patients of any benefits which they currently enjoy. There are few savings associated with de-listing benefits — perhaps $10 million (one-quarter of one percent of the OHIP budget). On the other hand, real savings could accrue from the structural reorganization of medical services.

Ontario spends hundreds of millions of dollars every year on inappropriate medical services. This point was noted by the Ontario Health Review Panel (Evans Report) in 1987:

"Evidence of inappropriate care can be found throughout the Province's health care system, from inappropriate institutional admissions to overuse of medications among the elderly."[1]

Other provinces' commissions on health care have come to similar conclusions.[2,3] Although it may be relatively simple in retrospect to determine that a particular diagnostic test or therapy has not helped an individual patient, *an inappropriate service should be defined as one which the best scientific evidence would indicate in advance would be of no net benefit to the patient or one which could be predicted to be of no more benefit than one which is less expensive.*

Using this definition, there is substantial evidence of the provision of inappropriate services.

- There are dramatic differences in the rates of delivery of certain services between different geographical areas despite the similar health status of the populations.
- A large proportion of services are labelled as inappropriate when expert panels are convened to define standards of care for particular illness episodes.
- If consumers are allowed to make informed choices about their care they often choose different services than if the options for care are presented in a traditional fashion.
- Different methods of paying doctors changes the volume and mix of services (with no effect on health status).
- Many medical services could be provided by non-physicians (such as nurses) with less cost and, sometimes, improved quality.

I will discuss a few of these points in more detail and make some specific recommendations.

Reducing the use of fee-for-service to pay Ontario doctors

It has been noted for some time that the fee-for-service method of remuneration increases costs by 25 to 40 percent without commensurate improvements in quality.[4,5,6,7,8] There are some caveats which must be added to this research but they don't change its overall results.[9,10] The OMA and the provincial government are moving at a snail's pace in developing alternatives to fee-for-service. In fact, the province has actually decreased the number of new community health centres to be funded from the six per year planned by the previous government to three. The Ontario chapter of the Canadian College of Family Physicians and the Ontario Professors of Family Medicine have recently recommended largely moving family physicians away from fee-for-service remuneration but the response by both the OMA and the government has been underwhelming.

Recommendation #2

The Ministry of Health should strike a committee composed of representatives from the Ontario Medical Association, the Ontario Chapter of the Canadian College of Family Physicians, the Ontario Professors of Family Medicine, the Association of Ontario Health Centres, the Registered Nurses Association of Ontario, the Ontario Hospital Association and other relevant professional and consumer organizations to develop new payment methods for Ontario doctors.

Hundreds of millions of dollars could be saved from payments to doctors by the more appropriate utilization of other health professionals and increased self-care

We have known for decades that many doctors' services could be provided as well or better by nurses or other health professionals.[11,12,13,14,15] Family doctors and emergency departments spend much of their time dealing with people with minor illnesses which people could be taught to manage themselves.[16,17,18] The best way to implement better use of non-physician professionals and increase self-care would be to reform the system of primary care and dramatically increase the number of community health centres and health service organizations (HSOs). The province has been avoiding fundamental reforms for primary care and has instituted a number of bureaucratic barriers which will prevent any such reforms for at least two years.

Recommendation #3

The Ministry of Health should scrap their current stalling strategy for primary care reform and implement a fast-track plan to ensure that half of all Ontario residents receive primary care services through community health centres or health service organizations by 1997.

Respect patient preferences for care

It is increasingly appreciated that a patient's own values and preferences might

Continued on Page Seven

be the key factor in determining appropriateness for many services. This is particularly true for elective procedures but the point also applies to some curative procedures.[19] Recently researchers have used interactive video disc technology to allow patients to become informed about elective prostate surgery. When patients have an opportunity to tailor their counselling they are half as likely to request surgery as those patients who simply discuss the procedure with a surgeon.[20,21] Other research has indicated that physicians are poor communicators, misreading patient preferences and frequently misunderstanding what their patients have really said.[22,23]

Recommendation #4

All patients who are referred for elective surgery should be offered an opportunity to discuss their surgery in detail with an appropriately trained counsellor. Similar patient-centred counselling should also be a key feature in long-term medical therapies such as treatment of mild hypertension and hypercholesterolemia.

Quality Assurance needs to become a routine part of medical practice

No other major sector of the Ontario economy so fundamentally lacks quality assurance as does clinical medicine in Ontario. Much of medical practice lacks guidelines or standards. When guidelines are promulgated, they are often not observed. There is little formal measurement of clinical performance. Finally, there are few effective levers to alter physician behaviour if for some reason it is measured and found wanting. There are some major success stories in quality assurance, but they are still too rare. Ironically, an Ontario pilot project which reduced cesarian section rates has been hailed in the United States while lacking replication here.[24]

Recommendation #5

Each specialty area of clinical medicine should undertake to publish at least three guidelines covering significant portions of clinical practice within twelve months. The specialties should ensure that the achievement towards fulfillment of the guidelines is measured and improves within a three year period. The process should be convened and jointly administered by the College of Physicians and Surgeons of Ontario, the Royal College of Physicians and Surgeons, and the Ontario Medical Association. Appropriate assistance should be provided by government, universities, and other professions.

Conclusion

The JMC has attempted to position the debate about medical care as a choice between which patient's needs are more legitimate than others. However, almost all services are appropriate for some persons at some time. The real debate should be about how to improve the appropriateness of care without reducing services to patients. The JMC is a major impediment to such an informed debate.

Recommendation #6

The Government of Ontario should disband the Joint Management Committee and institute a broad planning/community development process to reform the province's medical care.

Endnotes:

1. The Report of the Ontario Health Review Panel. (Chair Dr. John Evans) Government of Ontario. Toronto. 1987.
2. Report of the Commission on Selected Health Care Programs. (Co-chairs Mr. E. Neil McKelvey and Sr. Bernadette Levesque) Government of New Brunswick. Fredericton. 1989.
3. The Report of the Nova Scotia Royal Commission on Health Care: Towards a New Strategy. (Chair Mr. J. Camile Galant) The Government of Nova Scotia. Halifax. 1989.
4. Hastings JEF, Mott FD, Barclay A, Hewitt D. Prepaid group practice in Sault Ste Marie, Ontario: Part I: analysis of utilization records. Medical Care. 1973; volume 11: pages 91-103.
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Continued on Page Eight

MRG critical of proposed delisting

The following brief was submitted by the Medical Reform Group to the Joint Management Committee Panel reviewing the schedule of benefits.

The Medical Reform Group is critical of the proposed delisting of 19 medical and surgical procedures from the OHIP fee schedule. When the original list of 14 was made public in 1992, we believed this approach to be a serious threat to medicare in the province. Even with the new and more rigorously defined categories, we are still convinced that any focus on delisting continues to risk the creation of a two-tiered system, with no guarantee of any significant decrease in health care costs.

The Medical Reform Group was established in 1979 out of a commitment, by its founders, to the principle of health care as a right, and a recognition of the basis of health as social and political in nature. We agree that the Ministry of Health should consider deletion of services for which there is **no** proven benefit and applaud their responsiveness to public participation in these discussions and decisions. But it is clear from the 'qualifications' of the JMC list that almost every considered procedure has 'medical' indications, if by that we mean that we understand health to have a broad definition which includes emotional well-being and quality of life, not just its prolongation. We are alarmed that the 'bureaucratization' of these distinctions will have several effects:

1. Delisted services will have no limit on the fee that the physician can charge. This was our initial fear of a two-tiered system for those who can pay and denial of services to those who can't, but for whom there may be a legitimate need.
2. Delisting encourages direct charges to patients. Third-party billing has essentially delisted the annual health examination (Item 12), which in the absence of any 'diagnosis' is most often done at the request of an insurance company, school, summer camp, etc. Many of us in general practice know that 'sick note' charges are rarely passed on to the employer, but are 'out-of-pocket' expenses for the patient. We are also aware of excessive charges to patients for services such as the transferring of records (e.g. a patient was charged $30 for photocopying of an obstetrical ultrasound report: personal communication, Dr. Rosana Pellizzari). Mr. Bill Mindell, of the City of York Health Unit reported that children were prevented from attending school because parents could not afford to pay a $40 physician fee to complete a Tuberculosis Control form required by public health officials. These are clearly the equivalent of "user fees".
3. Physicians will use their "OHIP-allotted" billings to provide other insured services, challenging the argument that health care costs will, by this approach, be lowered in any significant way. In a fee-for-service system physicians have every opportunity to maintain their incomes.
4. The other possibility is that physicians will be tempted to provide more delisted services, for two reasons — they are more lucrative and they promise an easier 'physician lifestyle'. To quote a Chief of Surgery: "If doctors can set their own fees for these (delisted) services and in a sense work outside the system, why would they continue to treat trauma patients? This way they make good money and don't have to get up at 2 am." (Dr. Girotti, *Ontario Medicine*, 20/9/93).
5. The notion of patient responsibility lives on the borderland of victim-blaming for illness. If we consider travel malaria prophylaxis to be an expense to the traveller (Item 14) what do we do if the prophylaxis 'fails' and our patient returns to Canada with malaria? What about suspected displastic nevi - they are benign but potentially malignant - will they be 'covered'? (Item 9). We are very concerned that we will see a repetition of the 'therapeutic' abortion committees which presumed to judge the 'medical necessity' of a woman's choice.

What seems to be a benign plan on the first glance is not. It may be tempting to 'cut and slash' what appear to be the offending agents of our health care system, but our precious energy needs to be re-directed to substantial reform of a primary care system that has revealed its weaknesses. The Medical Reform Group has repeatedly called on provincial governments to reform the delivery of primary health care. We have strongly supported alternative methods of physician remuneration and have called for the recognition of other health care workers in the system. We advocate that the fee schedule apply only to specialists, laboratories, and diagnostic imaging services and that primary care be based on a salary or capitation system which includes monitoring and accountability. We ask the NDP government to abandon this misguided and hazardous project to 'delist' services, and renew its commitment to the principles of the Canada Health Act - that it be universal, accessible, and comprehensive.▼

Dr. Rosana Pellizzari and Dr. Mimi Divinsky for the Steering Committee of the Medical Reform Group of Ontario.

Delisting - A Flawed Process
Continued from Page Seven

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Michael Rachlis

What Moves A Doctor

There is sometimes an air of other worldly unreality surrounding progressives. This can be and usually is, counter-productive to their long term goals of effecting social change. Amongst one of the "unrealities" is a sort of sectarianism, that states only explicitly politically progressive doctors are motivated by forces other than money. This is effectively refuted by John Berryman, the American poet, in this excerpt from a forthcoming book:

From "Why I've become the poet I've become: John Berryman..." by Philip Levine, The New York Times Book Review, December 26, 1993:

"Berryman immediately demanded a poem from the hangers-on. The poem described conventional distaste for the medical profession by dealing with the cliches of greed and indifference to suffering. We later learnt it was written by a doctor's wife. John Berryman shook his head violently. "No, no," he said, "it's not that it's not poetry. I wasn't expecting poetry. It's that it is not true, absolutely untrue, unobserved, the cheapest twaddle."

Then he began a long monologue in which he described the efforts of a team of doctors to save the life of a friend of his, how they had struggled through a long night, working feverishly. "They did not work for money. There was no money in it. They worked to save a human life because it was a human life, and thus precious. They did not know who that man was, that he was a remarkable spirit. They knew only that he was too young to die, and so they worked to save him, and failing wept." It turned out that the man was Dylan Thomas.▼

Submitted by Haresh Kirpalani

Bush visit protested

The following letter of protest was sent when it was announced that former U.S. President George Bush would be the featured speaker at a fund-raising dinner:

As faculty members, we are very disturbed at the Faculty of Health Sciences' involvement with George Bush's featured presentation at a fund-raising dinner in Hamilton. George Bush represents the antithesis of everything we are trying to achieve in health care in Canada. As President of the United States, Bush defended, indeed lauded, the American health care system, the least equitable in the more-industrialized world. He was unconcerned about the millions of Americans who, due to financial barriers, do not receive adequate health care. He did everything possible to resist changes that might address the injustice in U.S. health care, while pursuing social policies which have contributed to the deterioration in the health of the poor and disadvantaged in the United States.

To defend U.S. health care, George Bush and his cabinet colleagues repeatedly lied about and misrepresented the Canadian health care system. They painted a picture of an inefficient, exorbitantly expensive, technologically backward system, in which patients couldn't choose their physicians. They claimed we deliver poor care, and our health care system didn't serve Canadians' interest. The reality, as you well know, is that we are deliver care far more efficiently and equitably than does the United States, and our population is appreciably healthier.

What can Canadians learn from a man whose values are antithetical to ours, and who was so ready to lie about us to serve goals which were antagonistic to the health of Americans? Our health care system is under threat, and the pressures to abandon equal access and social responsibility are growing. In such a time, what message do we give when we endorse the visit of a man who represents everything we are trying to avoid in our health care system? The message is altogether wrong, and we deeply regret any part that our medical community has had in this event.▼

LETTERS

Prescription drug reform: maybe universality?

I would like to respond to the piece by Gord Guyatt in the November 1993 Medical Reform "NDP performance diverges from principles". It is gratifying to be able to state that the decision to charge user fees for prescription drugs for seniors will not be taking place. The decision was announced the week after the predictably inaccurate New York Times had mentioned in an article that Ontario had already implemented the charges.

I am proud to be one of those who stood up and argued against the proposal and I want to point out that decisions are not carved in stone. I would encourage the MRG and its individual members to put forward their concerns and objections. As always, the informed and disinterested concerns of qualified physicians can carry considerable weight, particularly when it supports the objections of those more directly affected.

I would hope this can be an important milestone in a move towards universal coverage of essential drugs. At the present time the government plan covers 25% of the population. While many people are in private plans, there is an important sector with no coverage. Many of these are the working poor or self-employed.

I have been advocating an insurance plan, similar to OHIP when there were premiums. There could be the same exemptions and reduced premiums. I suspect that the premiums could provide the revenue that was being looked for and that broad accessibility would be a popular step towards social justice. It scarcely need be said that we must continue with rationalization of the drug formulary and changes in prescribing habits. Gord's observation that physicians receive minimal feedback on their prescribing is noted.

There are several other points in Gord's article that need to be responded

Continued on Page 10

Write! Fax! Mail!

Do you want to react to something you've read in Medical Reform, or to something an MRG spokesperson said on the radio?

We encourage debate, and welcome your letters and articles. If you have a comment to make, or a subject you would like to write about, sent it to us. Make Medical Reform your means of communicating your ideas about health care.

Submissions may be faxed to: (416) 588-3765, or mailed to: Medical Reform, P.O. Box 158, Station D, Toronto, Ontario M6P 3J8.

Prescription Drug Reform
Continued from Page 9

to, but I have chosen the drug issue because the decision not to have user fees opens things up for some positive initiatives. I'd welcome feedback on my proposals and will bring your suggestions forward at Queen's Park.▼

Bob Frankford, M.D. *Bob Frankford in the NDP MPP for Scarborough-East*

CHCs defended

We are writing in response to the article submitted by Drs. Roedde and McLeod ("Different Vision of Health Care", November 1993 issue of *Medical Reform).* The Association of Ontario Health Centres (AOHC) is the provincial organization representing the interests of all community health centres (CHCs) and some health service organizations (HSOs) in Ontario. We recognize that your newsletter encourages debate on various issues, however we believe that **responsible debate should be based on facts** and not on unfounded allegations as noted in the above article. We are referring to the allegations related to "the CHC" and details regarding some practices in "the CHC". There are only four CHCs in Northern Ontario so it was not too difficult to find out that the CHC being referred to is the Ogden-East End CHC in Thunder Bay. We have been in touch with Ogden East End CHC and it is our understanding that they will be responding directly to the unfounded allegations contained in the article.

Our particular concern is the statement in the article which states you only need to look at other CHCs "to see other examples of similar waste." This type of sweeping condemnation requires proof otherwise it falls in the category of gossip and rumour mongering — a barrier to an appropriate and effective health system. We also encourage debate and respect the right to disagree of those whose opinions differ from ours but unsubstantiated allegations must no longer to tolerated from anyone, notwithstanding an M.D. C.C.F.P. designation. The burden of proof lies with the authors of the article. There are a total of 49 CHCs in Ontario and we would be interested to know what other CHCs the authors were referring to as well as what they would consider "waste". In fact, we challenge Drs. Roedde and McLeod to become involved, learn and contribute to the development of a better health system — one which does not focus on illness and treatment alone, but seeks to truly involve people in the creation of healthy communities. They have taken the time to make a contribution to the newsletter of the Medical Reform Group. They should have begun by first getting their facts straight.▼

Dennise Albrecht
President, Association of Ontario Health Centres

CHC approach long-term and preventative

We are responding to the submission by Dr. Roedde and Dr. McLeod in your November 1993 issue. Given that we are the only CHC in Thunder Bay where the two doctors practice it is apparent that we are the CHC to which they are referring.

As the Board of Governors of a Community Health Centre we question the true intent of these doctors to "work to change things at a local level" when they do not initially bring their concerns to us. We wonder how well the physicians know our population let alone what if any appreciation they have of the community health centre concept. We are not a fee-for-service operation and to compare the volume of a physician based practice belies a complete misunderstanding of the holistic manner in which a CHC functions.

Many of our resident population do not routinely seek medical/social help until they are in a crisis. The Community Health Centre model allows us to reach out to this population where they are and on their terms. For example, we have our community health nurse "hang out" in the mall with our teen moms. She is able to offer advice/information and encourage them to begin to utilize our many other resources. This innovative approach is one of many which enables us to reach and work with a population which is traditionally very costly to both the social and medical system.

Our approach is long term and preventative. We are unique in Thunder Bay. The "one" administrator oversees a multi-faceted team of "8-1/2" staff. The professional team functions synergistically to deliver a multi faceted, as opposed to unilinear service.

It appears that Drs. Roedde and McLeod wanted to let you know why they chose not to renew their subscription to your publication. It is surprising and disheartening to have the reputation of our CHC abused in that context. We live in a very small community in which doctors rather than other CHCs form our community of peers. We welcome an open dialogue with the medical community. However as proponents of the community health movement we will not compromise our basic principles.▼

Margot Morgan
President of the Board
Ogden-East End CHC

HSOs cost-efficient and progressive

I wanted to write a note in support of Bob James' article in the November issue of *Medical Reform*.

I fully endorse his comments. The HSO programme, based as it is on capitation payment of physicians, is probably the most cost-efficient, progressive alternative to fee-for-service. Studies from England, Finland and the U.S. show capitation to be more efficient than pure salary.

At a time when the fee-for-service system is widely recognized to be bankrupt, this Ministry of Health is on a course bent on destroying the HSO programme. While I am certainly not starving, I am taking at least a 22% cut in my personal income and monies for improved patient care have dried up.

Contrast this with the CHC programme and the agenda of the Ministry is clear. The biggest winners in the Social Contract negotiations are CHCs.

By the way, I earn about 65% of the salary I would receive in a CHC!▼

Fred Freedman

Community health centres not the enemy

Since I am one of two Steering Committee members employed by a community health centre, I would like to respond to Fred Freedman's letter to the MRG [see above]. I am puzzled as to why he has identified CHCs as the enemy: the CHC programme as a whole and individual CHCs themselves have not been spared from Social Contract cuts. Programs and staff earnings have been affected.

If we have not been clear enough in the past year, then we must say it again: the MRG supports an accountable structure of primary care which is based on rational planning, monitors and assesses outcomes, addresses the social and economic roots of ill health, gives a greater role to non-physicians, and reimburses physicians through a capitation or salary mechanism (Resolution passed at November 1992 Semi-Annual Meeting).

That resolution was followed, in December, by a letter to the Minister of Health voicing concern over HSO negotiations. Since passing the resolution, the steering committee has voiced its position in several media interviews and in both its brief arguing against Bill 50 (the government's Expenditure Control Plan), and in the recent letter to the panel contemplating delisting. All this was in spite of the fact that the HSO programme in Ontario was a disaster, poorly administered, under-monitored, a virtual cash cow for the unscrupulous. It is a little known fact that the mean annual HSO payment per physician in 1992-93 was a healthy $375,000.[1]

If the MRG has not been more vocal in the current contract negotiations in the HSO Programme, it is because negotiations occurred in camera: no information was made available to the public. We predicted this in our November 1992 Newsletter: "the recent OMA-MOH Agreement has firmly entrenched the HSOs in the physician camp, effectively limiting public debate and discussion. It is ironic that despite the international and historic support for capitation as a preferred model for physician remuneration, capitation in this province is undergoing such a struggle."[2]

Fred Freedman is incorrect in his assertion that the HSO programme is the most "cost-efficient" alternative to fee for service medicine. Given the unaccountability of our present system, and the lack of accurate outcome measures, we are unable to compare the three different models. Costs actually rose dramatically for physicians who jointed the HSO Programme in Ontario (Reference 1). A recently completed study by CHEPA has found no difference in hospital utilization by physicians who converted to HSOs.[3] If Fred has evidence to support his statement, I hope he will share it with us.

What we should have learned in this province is that whatever model one implements, it must be monitored and evaluated with all providers accountable for the way in which resources are deployed.

It would belittle the discussion on health reform to begin or end our debate with the concern about how much physicians earn. There are many people in this province who would love to have our pay cheque, regardless of its magnitude, in their pocket. What would be more valuable would be to continue our discussion of first principles, as we have done in our work on resource allocation.

What do we wish to accomplish with our primary health care system in this province? What should it include? Perhaps we already have general support for the Alma Ata definition of primary care as a composite of promotive, preventive, curative and rehabilitative services, reliant on an interdisciplinary team, built on the fundamental right of people to participate in the planning and implementation of their health care. In any case, whatever the organization, delivery and scope of primary health we support or recommend politically, it should be grounded in a clear vision of our goals and objectives.

We have had some accomplishments in identifying the elements of a model for primary health care. Fred Freedman and Bob James' work in the MRG Primary Health Care Group was fundamental. Many of us have carried that work forward through participation in policy debate and research. Our priority must be to continue to challenge and propel this government's rhetoric into action on health reform to achieve the structural changes which will support the MRG's founding principles and vision.▼

Rosana Pellizzari

1. Communication with Jim O'Neill, Community Health Branch, Ministry of Health.
2. Pellizzari, R., Whither HSOs? in Medical Reform Newsletter, 1992;12:4, pg 4.
3. Communication with Brian Hutchison, McMaster University

On Liberals, Tories, and NDP — All Birds of a Feather

by Haresh Kirpalani

"A man's a man for aw that", said the great poet Robert Burns.

It should be also said that a capitalist is a capitalist, and a worker is a worker, for all that. But strangely, words like worker and capitalist do not seem part of the vocabulary any longer. Do these words stick in people's throats?

How to project where progressive medical opinion should go over the next period? This requires an assessment of where we've come from. For me, an inescapable conclusion is that we have come from trying to maintain an independence from the USA, and we are going towards a form of close union with the USA. Is this really true, and what does it mean? The basic premise of this article is that Canadian medical care and social benefits have only been possible because of Canada's independence — weak though it was. Given an analysis that the Canadian state will be "blended" into the North American Free Trade Agreement, this will have obvious implications for the universal health care system.

It was Walter Gordon, chair of the 1955 Royal Commission who fingered U.S. investment into Canada as a major concern, leading to "Canada's eventual absorption."[1] (J.L.Granatstein and N.Hillmer, For Better or Worse: Canada and the USA to 1990, Toronto, 1991. p. 221). As Finance Minister, he took steps:

i) He taxed at a rate of 30% all sales on shares in Canadian companies to non-residents, and

ii) He revised the 15% withholding tax on dividends to non-residents to favour shareholders in companies that retained substantial Canadian ownership.

Howls of protest from big business resulted. Even the Governor of the Bank of Canada warned of "massive liquidation" of American investment. Gordon was forced to recant. Quite oblivious to the hypocrisy, the USA then itself created an interest equalization tax aimed at foreign outflow of gold and capital.

But the Canadian capitalists did not give up - yet. The USA after all was "poorly", and they saw their chance. A weakened USA in the 1960s was forced to end the convertibility of the dollar into gold. Moreover President Nixon retreated from the "free" market place and imposed a 10% surcharge on all dutiable imports. Tokyo called this the "Nixon shokku".

Canadian business had of course a lot to lose by this surcharge. Trudeau argued: "We will have to reassess fundamentally our relations with them — trading, political and otherwise." (J.L.Granatstein, ibid, p.247) So was born the so-called Third Option, heralded by Herbert Gray and his Report. Again the U.S. spectre was identified. Gray called for massive state intervention:

i) To take over or review all foreign owned companies;

ii) To license and franchise all foreign companies;

iii) To vet foreign money and ownership from the "national" viewpoint by Foreign Investment Review Agency (FIRA);

iv) To establish control over the lucrative resource — oil. The National Energy Policy (NEP) of 1980, was the nationalists' centrepiece, aiming to make hay while oil prices sky rocketed.

In the 1970s, huge energy reserves were found in the Arctic and Western Canada. This entered the equation of battles in the Middle East over oil control. Canadian capitalists misread the tea leaves. The USA had artificially created a so-called 'energy crisis' in order to make its own reserves of shale bearing oil a profitable venture; and to enhance profits of the oil companies. The 'crisis' was manufactured by these big oil companies, "The Seven Sisters", mainly US-controlled. Finance Minister Allan MacEachen proposed that by 1990 there would be at least 50% ownership of all oil and gas companies in Canada. Jim Laxer, ex-Waffle member, calls NEP: "the most significant act of government intervention since the Second World War. It was the most ambitious effort ever undertaken by Ottawa to reverse the foreign control of a major industry in favour of Canadian control..." The NEP was to: "restructure Canada's energy system to balance domestic oil supplies with domestic demand by 1990, achieve an equitable sharing of energy benefits and burdens among Canadians, lead to a higher level of Canadian ownership and control of the energy sector. (James Laxer, Oil and Gas: Ottawa, the Provinces, and the Petroleum Industry. Toronto, 1983, p.74)

Moreover NEP would shift significant consumption in Canada to local gas, away from mainly foreign oil. The Seven Sisters wanted oil prices to go, to get more profit. The NEP naturally was unhelpful to them. Not surprisingly, this did not go down a bundle with the USA. By 1980, when Ronald Reagan had come to power in the USA, the American capitalist class had forced a retraction. The NEP was largely blocked. Pipelines from the North were blocked on grounds of environmental safety, and somehow Hibernia oil drilling in the Atlantic off Newfoundland was abandoned. And FIRA was never enacted rigorously.

After their long struggle, dating from the days of the United Empire Loyalists, the Canadian capitalists were forced to concede defeat. They finally threw in the towel. After this massive defeat, it was clear to them, that the Canadians could definitely no longer go it alone in the newly so-called Globalized Economy. They decided to once and for all, to get well and truly into bed with their elephantine neighbour next door, as the famous jest by Trudeau would have it.

But since the days of the United Empire Loyalists, the Canadian ethos, people and bi-national state (English Canada and French Canada) had come into being.

Why would the Canadian people be willing to see themselves turn into weak-coloured Americans ? To "persuade them", it was necessary for Canadians to be all shook up.

The capitalist class now needed to disillusion the die-hard nationalists: the majority of the people of Canada.

After all, Canadians had a welfare system, a social security system, a good health care system, cities that were not yet murderous gun ranges, stronger labour organisations, some social democratic traditions; all forming a way of life distinctly less brutalised than the people of the USA. The Canadian people were hardly going to give this up easily. They had to be first disillusioned. Their faith in a separate way of life had to be profoundly shaken. In effecting this sea change, "Free Trade" became the domi-

nant strategy, and debating point.

Previous discussions on "free trade" had always been a code for penetration of the USA into Canadian market.

Now however this "discussion" was facilitated by "insider trading". There was a clear comprador relationship between the dominant faction of Canadian capitalists and the USA capitalists. The word comprador originally meant the trader capitalists in colonies, whose profits depended upon their links as middle men with foreign imperialist capitalists. It came to mean all capitalists whose primary profit base is totally dependent upon their link with foreign capitalists. In Canada, they were originally linked to Britain — the "Mother Nation".

But the old pro-British "comprador" forces knew that Britain was "down the tubes"; and had switched horses now to become pro-USA compradors. They were led by Brian Mulroney, that great reactionary toady to American imperialism. But by now, the Liberals, erstwhile representing the national capitalists had also signalled their switch to alliance with the USA capitalists. In the election of 1984, after Trudeau's resignation, a poor candidate was selected for the Liberals, John Turner. Turner's dismal and bumbling showing allowed the Tories to enter with a stated agenda - Free Trade.

Mulroney rapidly changed Canada's direction, firmly climbing onto the US bandwagon. Despite a cut-throat slash at the "welfare state"; Canadians were conned into voting him into power for two terms. Conned because no effective opposition was presented. The second term elections were made into a Referendum on Free Trade with the USA.

Despite clear signs that Free Trade would decimate business in Canada, prompting further unemployment as industries went south of the border; the electorate were manipulated. The Liberals and the New Democratic Party, despite rank and file labour, sabotaged any struggles. They did this by the simple expedient of NOT organising a comprehensive well run anti-Free Trade Coalition. Spontaneous mass organisation did occur. But without a united political front at the polls, this was doomed. Not facing any serious effective opposition, Mulroney after a victorious election pushed through Free Trade. The dire consequences previously only predicted, came to pass.

However one further set of tasks were left to be done by Mulroney. This was to rupture the relative harmony that had been present in the functioning of the state between French Quebecois and anglo-Canadians. This would allow the possible disintegration of the Canadian state leading ultimately to a wholesale absorption into the USA. This was the function of the so-called constitutional crisis which engulfed Canada over the last two years.

The British North American Act of 1867 formed Canada's Constitution, and was renamed the Constitution Act. This established the House of Commons and the Senate, the powers of each, the provincial powers, the federal powers, legislation, etc. In 1982 there were two amending acts. The Canada Act transferred to Canada the power to amend the Constitution from the British House of Parliament. This is known as the "patriation" of the Constitution. The second amending act was the Canadian Charter of Rights and Freedoms of 1982, which entrenched in the Constitution protection of individual rights and freedoms of religion, assembly, association and the press.

But the Constitution Act of 1982 had not been signed by the Quebec Premier at the time, Rene Levesque. He refused on the grounds that the Act did not adequately protect the French interests. Manifestly, this refusal had NOT impeded government in any way since 1982. But it was made the pretext of a new constitutional move. This was the Meech Lake Accord. By this means, Quebec would be "included" into the Constitution.

When in 1987, the Quebec government under Robert Bourassa (Liberal Party) was asked to agree, it presented five pre-conditions. These aimed at preserving and extending Quebec's privileges:

1. Recognition of Quebec as a distinct society.
2. A provincial role in appointments to the Supreme Court.
3. A greater provincial role in immigration.
4. Limits on federal power in federal-provincial shared-cost programs.
5. A veto for Quebec on constitutional amendments. (Marjorie Montgomery Bowker, The Meech Lake Accord: What it will mean to you and to Canada. Hull, Quebec, 1990. p.17)

Naturally, other provinces objected to these privileges. These objections were valid. In addition:

1. The process in which this was done was deliberately designed to alienate Canadians, fostering rivalries and chauvinist sentiment.

Meech was all done supposedly "secretly" without the public knowing what the clauses were, etc. Of course this could not be, and was not meant to be, kept secret. It was inevitably 'leaked', inflaming Canadians when they heard that 'secret negotiations' were ongoing.

2. An underlying basic truth was that Quebec is a separate nation.

Because the parties did not venture this truth, the resulting tangle ensued. The privileges demanded by Quebec, and granted to it — but not Newfoundland were justifiable, if Quebec is a separate nation, and Newfoundland is not. Recognition of a separate nationhood up to and including the right of secession, does NOT automatically mean that there should be separation. Multi-national states have existed easily before and now. Disintegration of states like Yugoslavia has more to do with imperialism's wishes than anything else. Indeed it may be totally against BOTH Quebec and Anglo-Canada interests to separate.

Furthermore, the "distinct society" clause was an insulting nonsense, because life in Newfoundland IS distinctly different to that in Alberta and that in Ontario. The native Indian way of life IS distinct from the non-Indian. The whole dishonesty was calculated to inflame regional sensitivity and chauvinism to French nationhood.

By dishonestly not calling Quebec a nation, all parties predictably exacerbated all the problems.

All leading politicians knew this tangle would become unresolvable. They also calculated upon the side-effects of obfuscation and alienation of the public.

3. The actual Accord itself contained some retrogressive clauses which the Government let be exposed.

They anticipated that once alerted and provoked, the public would react strongly against these clauses. The basic strategy for the capitalists and their representatives was straightforward, a win-win strategy. Remember, they wished to effect in deed if not in word, the practical unification of the USA with Canada.

On the one hand, if Meech did not pass, the process would have thoroughly alienated Canadians, facilitating any later attempt at disintegration:

But, if Meech against the odds did pass, then the job of disintegration of Canada would have been done.

Continued on Page 14

Birds of a Feather...
Continued from Page 13

The federal link was being dissolved into a provincial power. This did put no restrictions on welfare protection etc. The federal programs including Health were subject purely to Provincial specification.

An effective veto was placed on any changes in the future on the Constitution, for any of the provinces as unanimous approval was required.

Any attempts at Senate reform (a hot bed of patronage and corruption) was likely never to occur.

The Yukon and Northwest Territories were basically ignored as posing any constitutional weight.

The Meech Lake Accord was very patently never meant to pass. The whole manner of its failure was a farce, including the episode where the Premier of Newfoundland was told first one thing and then another, all was pre-calculated. The Premier of Newfoundland, Mr. Clyde Wells, was maneuvered into a position, whereby he had to reject the Accord. That a prominent member of the Alberta Legislative Assembly, Native Indian chief, Mr. Elijah Harper also rejected the Accord (on legitimate grounds of inadequate recognition of the Native Indians as a distinct society) was icing on the cake.

Now with much heavy sighing, and wringing of hands, the Charlottetown Accord was tortuously launched. Again it was launched in order to visibly fail. But it was orchestrated to be a public failure after a referendum on constitutional change. During this process, a deliberate obfuscation of the real issues bored and disillusioned the masses of Canadians who tried to understand the issue.

This alienation again aimed to accentuate differences. It left the residue of feeling in French Canada, "that the Anglos would not go the extra mile for them to stay within a federal Canada". Within the English part of Canada, it left the reverse flavour: "That the French were always asking for special treatment and favours, and despite giving them 'favours' they were never satisfied."

The national rejection of the Charlottetown Accord at the polls allowed the growth of further regional parties. Particularly in the West with the openly pro-fascist Reform Party. In addition the recently sagging Parti Quebecois had a resurgence under the Bloc Quebecois and the Parti Quebecois working together. The Bloc Quebecois was led by a former lieutenant of Mulroney's (Lucien Bouchard) whose spectacular departure from Cabinet signalled the new strategy of the ruling classes of Canada.

The strategy had been very simple. It consisted of fostering regionalism; to begin the process of dissolving Canada; to place free trade in a situation where it could not be reversed; and ultimately to join the USA. The Mulroney Government had performed its mission well.

But it had alienated the Canadian people to an extraordinary degree. The cynicism of the electorate was virulent against the Tories. Of course by now the ruling class had a degree of unanimity on the issue of the USA. Because the Liberals had signalled that they had been defanged. They were now obediently in the USA line-up.

Accordingly, an arrogant female clone of Mulroney — Kim Campbell — was made leader of the Tory Party. To make doubly sure that she did not win the elections, her campaign was at key points sabotaged. For instance, her handlers allowed her to say that elections were not the times that the electorate could be informed about serious policy decisions about welfare and health. The damaging nasty play of Chretien's facial deformity predictably backfired. This all allowed the Liberals to sweep into power again.

What then are the class allegiances of the current main parties in Canada?

Without a doubt, they all represent different sections of capital.

The Conservative party represents that section of Canadian capitalists whose interests have until now been mainly linked to USA capital. They have been in the main representing finance capital. They have been strong proponents of the reduction of inflation wing identified internationally with Mrs Thatcher and the Ronald Reagan.

The Liberal party represents that section of capital whose interests have until now been mainly linked to Canadian owned business. They have been representing both finance and industrial capital of Canada. But they have now become accommodated to the policy of future linkage with the USA.

The New Democratic Party represents the social democratic face of the Canadian capitalist class. Objectively they had till now, represented interests of Canadian national capital. Their approach is designed to divert the most advanced section of the working people into byways that supports and does not harm Canadian owned finance and industrial capital.

The NDP have been critical in the implementation of a harsh and brutal attack on the living standards of the Canadian people.

They have been in several provinces responsible for implementing cost cuts that the Tories and liberals would not have been allowed to get away with.

Consequently, they are seriously discredited with rank and file.

In this climate demagogic parties breed furiously. The Reform party appeals to the most reactionary section of petty bourgeoisie and small farmers. Predominant in the West, it exploits the large scale destruction of small scale family farms that has been ravaging the country. Objectively

they also represent the interests of the pro-US section of capital in Canada. But, the party has also signalled to the ruling class its willingness to be the vehicle for fascism at the juncture that the ruling class decides to take this route. But its greatest use thus far, has been for the capitalist class to further accentuate the divisions between Western Canada and the Central Canadians and "the French".

The Parti Quebecois has always been the representative of the Quebec national capitalist class. The Bloc Quebecois has been the vehicle by which the Anglo capitalist class signalled to the old Quebecois that they had some use for Quebec nationalism.

Finally, the National Party is the rump of the more determined nationalist capitalist class. Led by Mel Hurtig, the party suffered its major (probably fatal) blow with a split on the eve of the election. Maud Barlow, by backing the Liberals signalled the end of the road for the nationalist capitalist class.

As is abundantly clear there is no representative of the workers and the petty bourgeoisie.

So what does the ruling class want now?

The *Financial Post* is the standard bearer of the financial community. So, what advice does the *Financial Post* give to the Liberal party? In an editorial following the Liberal victory, editor Diane Francis demands a 5 point programme. Essentially it is more of the same:

Control the money supply; control debt; "Iron out a National Debt Discipline Agreement with the provinces to slash deficits across the board nationally by at least a third. Use transfer payments as punishment for provinces that spend

like sailors."; "Announce a massive privatisation scheme involving the sale of Crown lands, Crown corporations, exploration rights... etc";

But the final point again stresses fission of Canada:

"Embark on an ambitious devolution scheme that would mothball any unessential federal department. Ottawa should only manage the economy, foreign policy, internal security, and Crown lands and act as a coordination force among the provinces."

This is apparently a very different Canada from the past.

We must reject Diane Francis' vision.

Question: what is the game plan of the North American capitalists — both Canadians and Americans?

Answer: to harmonise the future North American free trade association state that is coming into being, they need fundamental changes.

Firstly, the trade union movement in the Canadian state must be severely weakened. This aim has already been largely achieved by the social democratic collaboration. The NDP bears the major blame for this, along with the trade union bureaucrats.

Secondly, the social welfare state of Canada must be levelled down to a more "slim and hard" version. This has happened and is further progressing now. The comments from leading officials of the Liberal administration e.g. Llyod Axworthy and Paul Martin. But, simultaneously, the USA has to obtain a slightly better social cushion than they have had hitherto. The American people were getting too restive, to ensure safety of the capitalist class. The Clinton administration have recognised this, and begun the first steps to a partial rectification of this. It must be said that the health care reforms are poorly conceived, and retain profit motives. But they are a step forward.

This means: harmonise !

Level down in Canada; whilst leveling up in the USA.

Thirdly, the North American Free Trade Agreement has to proceed. The hypocrisy underlying this can be expressed as "Free trade for me and my friends; Protective barriers against all our international imperialist competitors." It only should be reiterated that this is a fundamental strategy now for the USA imperialists to regain their superiority as an imperialist power. Indeed, it is critical to their survival as imperialists, as markets shrink all over the world.

In this overall context, fighting for the vestiges of Canadian independence is progressive. But clearly, without a party that represents the working people of Canada, "independence" for Canada is a shibboleth. Only the socialist revolution in Canada can effect meaningful progressive change.

I do realise that all this is a profoundly unpopular point of view. Perhaps however most progressives would agree with the following two slogans to provide some degree of unity:

Down with so called "free trade".

Down with an imperialist North American bloc.

What is the relevance of all this to health care progressives?

1. It is imperative to keep up pressure for universality of access — to health AND social programs.
2. Regardless of high falutin motivations of those arguing for rationalisation — their arguments will be woven into the fabric of cuts.
3. Sophistry about "Our Deficit" (opposed to The Capitalist Class's Deficits); just sees the surface of the struggle. Worse it plays into their hands.
4. Reliance on the NDP is criminally naive.▼

NEWS BRIEFS

Morgentaler wins in Nova Scotia

The Supreme Court of Canada has ruled 9-0 that the Nova Scotia government's ban on free-standing abortion clinics is unconstitutional. The ban was in essence a criminal law, although the government sought to present it as a health policy, the court ruled. *1 October, 1993*

Cross-border MDs rate Canadian system superior

A survey published in the November issue of the *American Journal of Public Health* found that doctors who have practised in both Canada and the United States rate Canada's health care system as superior to that of the U.S. The three main complaints of doctors practising in the United States were the lack of universal access to health care, the greater amounts of paperwork and bureaucracy, and the higher fees charged for malpractice insurance. Higher pay was the main advantage of practising in the U.S., and nearly half of the doctors who left Canada for the U.S. did so because of the pay. *9 November, 1993*

Hospital abandons epidurals

McKellar General Hospital in Thunder Bay has abandoned the use in epidural anesthesia during childbirth because of a shortage of staff. The hospital's anesthesia unit made the decision citing understaffing as the problem. "We're overtaxed," said James Middleton, head of anesthesia at the hospital." "We've had to close one of the operating rooms in the hospital over the last six weeks. I would say at least 120 people have had their surgery delayed in that time. So epidurals are one aspect of the problem, but not the only aspect." Dr. Middleton estimated that McKellar administers between 300 and 400 epidurals a year. The other major birthing hospital in the city rarely administers epidurals, and few of the smaller hospitals across Northern Ontario provide them. *9 November, 1993*

Welfare dental cuts cause pain

Metro Toronto's tough measure to reduce dental costs are "causing tremendous pain and suffering" among welfare recipients, according to a report by the West Central Community Health Centre. Metro chopped the dental services budget for welfare recipients to $12 million from $23 million in 1992. But even this lower budget wasn't spent, as welfare workers stopped telling people they were eligible. The result is that only half of the budget was spent. "Not only has the program been stripped to bare bones, recipients haven't even been told they're eligible for crucial emergency treatments," said Dr. Joel Rosenblum, a dentist who works out of the WCCHC. *10 November, 1993*

Shortage of radiation oncologists

Bernard Cummings, the chairman of the department of radiation oncology at the University of Toronto, has warned there will be a serious shortage of radiation oncologists in Ontario by the end of the decade. According to Cummings, the number of cancer cases in the province is increasing by 3.5 per cent a year with the result that "we are facing... great difficulty treating the number of patients who

would benefit from radiation, and governments are very slow to implement corrective measures. There is a slowness in the process, and during that interval patients cannot be treated." He said 87 radiation oncologists currently are practicing in the province, with another 64 in training at Ontario universities. By the end of the decade, there will be a shortage of 55 oncologists if nothing is done, Cummings said. *11 November, 1993*

Staying in bed not that bad

Forcing chronic care patients to stay in bed two days a week "isn't necessarily" compromising their quality of care, according to Lin Grist, a spokeswoman for Ontario Health Minister Ruth Grier. It's understandable that patients at West Park Hospital may be "feeling badly" because social contract cuts means there's not enough staff to help them get dressed and out of bed two days each week, Ms Grist said. "I'm not saying it's a brilliant suggestion but it sounds to me like it was, for them, the least disruptive way of meeting their (social contract) target," she said. Officials at the 398-bed chronic care facility in the City of York are meeting their target of $1.3 million in salary cuts by keeping some patients in bed two days a week. *15 November, 1993*

Province backtracks on user fees for drugs

In the face of criticism, the Ontario government backed away from its plan to make seniors pay user fees for prescription drugs. The Ontario Drug Benefit Program pays for prescription drugs for 2.4 million people, including those over 65 and those on welfare. The NDP government announced in June that it wanted to charge user fees to seniors with higher incomes, provoking an angry reaction from seniors' groups and others.

17 November, 1993

Berger chief of family medicine

Dr. Philip Berger, a long-time member of the Medical Reform Group, is now the chief of the department of family and community medicine at the Wellesley Hospital, Toronto. As well as his MRG activities, Berger is chair of the Toronto HIV Primary Care Physicians Group, and a founding member of the Canadian Centre for Victims of Torture.

22 November, 1993

Tenant law broadened

Ontario is extending tenant protection legislation to cover people living in unregulated care homes. About 47,000 people are affected, mainly seniors, former psychiatric patients and people with disabilities. Under the new legislation, tenants in care homes will be covered by the provisions of the Landlord and Tenant Act, which would give residents security of tenure, and the Rent Control Act, which will apply to the portion of the monthly charge that is for rent. Operators of the 2,000 to 2,500 homes affected by the legislation would also be required to register their charges for care and other services with the province's rent registry, and to provide residents with 90 days notice of increases in care service charges. Ernie Lightman, a social work professor at the University of Toronto who wrote a recent report on conditions in unregulated care homes, told reporters that tenant protection was the most important of his report's 148 recommendations. *24 November, 1993*

Alberta's user fees

Federal Health Minister Diane Marleau has said that she intends to review the Alberta government's decision to allow private medical clinics to charge patients large sums for operations which are available at no cost in the province's hospitals. The Canada Health Act prohibits doctors from charging more for a service covered by medicare than the amount set out in their provincial fee schedule. Some privately operated eye clinics in Alberta charge as much as $1,000 per patient as a "facility fee" for cataract surgery. The eye surgeon's fee for the operation, about $550, is paid by medicare, but the "facility fee" is not. Richard Plain, a health economist, said this is a clear violation of the Canada Health Act. "This is condoning extra-billing by ophthalmologists rendered under the euphemism of a facility fee. If a service is medically required, such fees are not supposed to be imposed without facing a dollar-by-dollar penalty. "What's happening is that if you go to a hospital for the operation, you face a long waiting list. If you step outside to a clinic across the street, and you've got a thousand bucks, they'll take care of you immediately." Mr. Plain said he is equally concerned about the recent opening of two private clinics in Alberta offering magnetic resonance imaging at $1,000 per scan. "Once again, if you can pay, you get right in," he said. "But any other Canadian, if it's a low-priority matter, will spend months on a waiting list." "The point is that medicare is supposed to ensure there are no financial barriers for access to insured services," he said. "They have no right to impose out-of-pocket expenses on the sick."

John Sproule, a spokesman for the Alberta Health Ministry, said the payment of a "facility fee" at eye clinics is no different from the extra fees charged by Alberta's free-standing private abortion clinic. "We pay the physicians for their services and the patients pay the facility fee." *24 November, 1993*

Reproductive technologies

The Royal Commission on New Reproductive Technologies released its long-awaited report on November 30. Among its major recommendations, the report recommends restricting in vitro fertilization to women with flocked fallopian tubes; ensuring that all women, including those who are single or lesbian, have equal access to medical procedures, specifically donor insemination; outlawing the selling of babies, embryos, fetal tissue, and sperm, for profit; making it illegal to arrange surrogate births; prohibiting prenatal testing to determine the sex of a child unless the testing is medically necessary.

1 December, 1993

Millions owed in back payments

The Ontario government is owed millions of dollars in back payments by doctors and not enough is being done to collect, according to the provincial auditor's report. Physicians must repay some of their fees once billings top $425,000. In the past three years, physicians were ordered to repay the province $6.8 million because of overbillings but the province collected only $3.1 million. The auditor's report also complains that MDs face no fine for repeatedly overbilling the province, being forced only to repay the excess money. It also says far too few physicians are referred to the committee that reviews overbilling.

8 December, 1993

Province offers salaries

The Ministry of Health is offering several hundred university physicians a deal that would pay them a basic salary plus

extra compensation for such things as overtime or surgery. The Alternative Funding Plan, which has already been agreed to between Queen's University and the province, is also being offered to physicians at universities in Toronto, Hamilton, Ottawa and London. The new faculty payment plan is anticipated to work far better for academic physicians than the current fee-for-service "treadmill," said George McLauchlin of the faculty of health sciences at McMaster University. *22 December, 1993*

Midwives join the system

Regulations governing the practice of midwifery in Ontario came into effect on January 1, making midwives a recognized profession under the Regulated Health Professions Act. Publicly funded licensed midwives will now be available for both home and hospital births. Initially about 60 midwives will be eligible to practice. They will be paid a base salary of about $55,000 a year, which can go higher or lower depending on the number of clients and experience. Most registered midwives will not be permitted to take on more than 80 patients a year or fewer than 20.

The Toronto Hospital has announced that it will now allow midwives to admit, manage and discharge patients. The hospital plans to appoint four or six staff midwives working in pairs.

1 January, 20 January, 1994

Hospitals propose merging services

Four downtown Toronto hospitals are proposing to form a consortium by merging some services to save money. Under the proposal, Mount Sinai, The Toronto Hospital, Princess Margaret Hospital, and the Hospital for Sick Children would share one biochemistry laboratory, security staff, grounds staff, pharmacy and food units. According to Dr. Alan Hudson, the CEO of the Toronto Hospital, tens of millions of dollars in annual savings are possible. *13 January, 1994*

Rural physicians set goals

The Society of Rural Physicians of Canada held its first national executive meeting — via telephone — on January 19. "We're discovering that rural physicians across the country have more in common with their rural colleagues than with their urban counterparts who may come from their own province," society president Dr. David Fletcher of Mount Forest said. "Rural is rural regardless of where you live in this country." Goals identified by the group include: (1) The need to respond quickly to rural health care issues from a national perspective; (2) The expansion to a monthly publication of the group's newsletter; (3) The creation of a national electronic mail network to allow continuous communication between members on issues such as hospital closures, physician shortages, and staffing of rural emergency departments. There was a consensus from members across the country that governments are moving from central to regional planning of health care, at the cost of rural medicine. "It means the largest urban centre in your region makes all the rules and sucks the resources out of the surrounding rural area," Fletcher said. "They promise the rural area 'outreach programs' in exchange, but the programs last no more than 12 to 18 months. Meanwhile the rural budgets are never returned to the rural area."

For more information about the Society of Rural Physicians of Canada, contact Dr. David Fletcher, (519) 323-1951, fax: (519)323-3881. *20 January, 1994*

Dialysis wait called critical

The president of the Toronto Dialysis Committee, Dr. Janet Roscoe, says that a critical shortage of resources for dialysis patients has confined some to hospital and others to severe pain while waiting for treatment. Dr. Roscoe also expressed fears that older patients may not even be getting referred for dialysis because of the huge backlog. The number of dialysis patients in Metro Toronto increased from 504 in 1981 to 1,422 in 1992 and is forecast to keep rising. The increase is attributed to an aging population and an increased incidence of diabetes. Meryl Hodnett, director of patient services for the Kidney Foundation of Canada, said some patients wait so long that they are in a "very poor state" by the time they get dialysis. "People are suffering with symptoms of renal failure and dying as a result of not getting the treatment," she said. In October, the health ministry provided emergency funding to place more people on dialysis as outpatients at two Toronto hospitals. The ministry has ordered a review of dialysis treatment, which is expected to be completed this summer. *22 January, 1994*

MEETINGS AND CONFERENCES

MRG Steering Committee

The Medical Reform Group Steering Committee meets on Thursday **February 24** in Toronto, on Thursday **March 17** in Hamilton, and on Monday **April 18** in Toronto. MRG members are invited to attend Steering Committee meetings to observe, take part, or raise issues the MRG should be addressing. For details on times and places, call 416-588-9167.

Physicians for a National Health Plan

The U.S. group Physicians for a National Health Plan is holding its annual meeting in Toronto on the weekend of **May 14-15**. A joint meeting with the Medical Reform Group is planned for the Saturday afternoon. **MRG members who would be able to provide a billet for PHNP members attending the meeting are asked to call the MRG office at 416-588-9167 or fax to 416-588-3765.**

MRG General meeting

The Medical Reform Group's Spring General meeting will be held on Saturday **May 14** in Toronto. A feature of this meeting will be a joint afternoon session with the U.S. group Physicians for a National Health Plan, which is holding its own meeting in Toronto this year in order to allow members to have a closer look at the Canadian health care system and to meet progressive Canadian health care professionals.

Helping the bereaved male

The twelfth King's College conference on Death and Bereavement will take place on **May 16-18** in London Ontario. The topic is "Helping the Bereaved Male". Contact King's College Centre for Education about Death and Bereavement, 266 Epworth Avenue, London Ontario N6A 2M3, fax: 519-433-0353.

Rethinking Primary Care

The Centre for Health Economics and Policy Analysis at McMaster University (CHEPA) is devoting its seventh annual policy conference to the topic of "Rethinking Primary Care". The conference will be held **May 19-20** at the Nottawasaga Inn in Alliston. Among the speakers are Julian Tudor Hart, a Welsh physician and an internationally known authority on alternative models of pri-

mary care, who will speak on Visions of Primary Care; Linda McQuaig, author of *The Wealthy Banker's Wife: The Assault on Equality in Canada* and *Behind Closed Doors: How the Rich Won Control of Canada's Tax System... And Ended up Richer*; and Julio Frenk, Director General of Mexico's National Institute of Public Health. Brian Hutchison, an MRG member, is the chairman of this year's conference. Registration is $220. For more information, contact Conference Administrator, CHEPA, McMaster University, 1200 Main Street West, Rm 3H26, Hamilton L8N 3Z5, (905) 525-9140 x22135, fax: (905) 546-5211.

Baby Friendly Initiative

Humber College, INFACT Canada, and Women's College Hospital are co-sponsoring "The Baby Friendly Initiative: A National Plan for Action" — a workshop for health professionals and policy makers to be held Thursday **June 9** at Humber College, 205 Humber College Blvd., Toronto. Contact Sylvia Segal, Humber College, 416-675-6622, fax: 416-675-2015.

Law and Mental Health

The twentieth Congress of the International Academy of Law and Mental Health will be held in Montreal **June 15-18**. Contact Karyn Wager, International Scientific Committee, 30 St. Joseph Blvd. E., #520, Montreal, Quebec H2T 1G9, 514-847-0782, fax: 514-843-5415.

MRG Fall General Meeting

The Medical Reform Group's fall general meeting has been scheduled for Thursday **September 29**.

It's Never OK

The Canadian Health Alliance to Stop Therapist Exploitation Now (CHASTEN) is holding a conference on sexual exploitation by health professionals, psychotherapists and clergy on **October 13-15** in Toronto. Contact Temi Firsten, c/o CHASTEN, P.O. Box 73516, 509 St. Clair Avenue West, Toronto M6C 4A7, (416) 656-5650.

PUBLICATIONS

Dental Services for Welfare Recipients

The West Central Community Health Centres have published a report on dental services for welfare recipients in Metropolitan Toronto. The report indicates that many welfare recipients are not receiving urgently needed dental care because of Metro's attempts to cut costs in its welfare budgets. The overwhelmingly majority of welfare recipients had not been told by their case workers that they were eligible for dental services. Most recipients didn't even know that they were eligible for emergency treatment.

Dental Services for Welfare Recipients in Metropolitan Toronto: A Consumer Perspective. Lynne Woolcott and Joel Rosenbloom, West Central Community Health Centres, 64 Augusta Avenue, Toronto M5T 2L1, November 1993.

Position Paper on Medicare

The Association of Ontario Health Centres has published a position paper on medicare. The paper includes a number of recommendations, including the negotiation of a federal/provincial arrangement which would ensure a federal financial commitment to medicare principles and enable the provinces and territories to uphold the principles of medicare; that the federal government prohibit provincial/territorial governments from applying user fees to hospital or physician services; remuneration for services using a system that is not volume- or procedure-driven; the expansion of health services to include health promotion, illness prevention and community development; and the reallocation of resources from institutional to community based services to ensure that health services respond to community needs.

A Position Paper on Medicare. September 1993. Association of Ontario Health Centres, 5233 Dundas Street West, #402, Etobicoke M9B 1A6, (416)236-2539, fax: (416)236-0431.

Complete Canadian Health Guide

The University of Toronto's Faculty of Medicine has published *The Complete Canadian Health Guide*, a comprehensive reference volume for consumers. The book covers healthy lifestyle, nutrition, environmental health hazards, as well as specific medical conditions.

The Complete Canadian Health Guide, June Engel, University of Toronto Faculty of Medicine, Key Porter Books, Toronto, 1993, 558 pp, $29.95.