MEDICAL REFORM

Newsletter of the Medical Reform Group

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Issue #93 — Volume 14, Number 5 — December 1994

Support for nurse practitioners as members of health care team

Health Minister Ruth Grier announced on December 13 that training programs for nurse practitioners are to be re-instituted. The Medical Reform Group's Steering Committee issued the following media release in response to the government's announcement:

Doctors' group supports nurse practitioners

Health Minister Ruth Grier today announced the re-institution of training programmes for Nurse Practitioners in Ontario. The Medical Reform Group of Ontario, representing over 200 Physicians, applauds this move as an important step forward in primary care reform in Ontario.

These new Nurse Practitioners will work primarily in health care teams involving Physicians, Social Workers, Nutritionists, Physiotherapists, and Occupational Therapists. Nurse Practitioners will focus on providing basic clinical care, treatment, advice, and information. They will have special training that will allow them to identify, investigate and treat specific illnesses.

Strong evidence from well-designed and executed research studies

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Clawback magnifies fee-for-service distortions

The Medical Reform Group's Steering Committee issued the following media release on December 18 in response to the implemenation of the Social Contract fee holdback:

Ontario's doctors will find their pay cheques docked by six per cent starting this month under a Social Contact provision negotiated between the provincial government and the Ontario Medical Association.

The clawback, which the OMA has decided to apply on a straight percentage basis rather than on a sliding

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General meeting debates

Can we define "medical necessity"? Do we want to?

The Medical Reform Group's fall general meeting examined the recent drive to define "medically necessary" services.

The Canada Health Act requires the provinces and territories to provide all medically necessary services, but does not define what medically necessary means. Governments — federal and provincial, Conservative, Liberal, and New Democrat — have been pushing for a formal legal definition of medical necessity, citing the increasing emphasis that all medical interventions should be based on evidence showing them to be of proven benefit.

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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.)

Send correspondence to Medical Reform, P.O. Box 158, Stn D, Toronto M6P 3J8. Phone: (416)588-9167,Fax: (416)588-3765. E-Mail: mrg@sources.com

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

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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.

Clawback Magnifies...

Continued from Page One

scale based on income, will penalize lower-billing physicians who typically take more time with patients, says the Medical Reform Group, a physician group critical of OMA policy.

"This will be demoralizing for the most conscientious physicians who are already under considerable stress," said MRG spokesperson Dr. Gordon Guyatt, "and therefore could potentially compromise patient care."

Under the social contract, Ontario physicians are subject to a "hard cap" of $3.654 billion in billings for the 1994-95 fiscal year, which ends March 31. Billings in excess of that amount have to be paid back. So far, the cap has been exceeded by $219 million, an amount expected to rise to $240 million by the end of the fiscal year. The current clawback will result in about $120 million being deducted, leaving another $120 million still owing.

According to the Medical Reform Group, the fee-for-service system under which most physicians are paid encourages "revolving-door" medicine. Doctors who practice high-volume medicine are the ones who bear the greatest responsibility for the increase in billings, but the clawback will be felt most severely by those at the lower end of the income scale whose billings haven't increased and who typically spend more time with patients, the MRG says.

"Instead of addressing the distortions caused by the fee-for-service system, the OMA and the government are acting in a way that will demoralize conscientious physicians while encouraging those who practice revolving-door medicine to make their doors revolve even faster," said Dr. Guyatt.

The Medical Reform Group believes that capitation and salary are preferable to fee-for-service as a method of paying primary care physicians.

The MRG also fears that the clawback will encourage more physicians to resort to charging their patients so-called "administrative fees" as a way of supplementing their income. "Administrative fees are a form of extra-billing, which is clearly prohibited by the Canada Health Act. The government should be acting to outlaw these regressive fees, not to encourage them", said Dr. Guyatt.▼

Nurse Practitioners...

Continued from Page One

supports Nurse Practitioners' effectiveness and efficiency in providing certain aspects of primary care. For a defined set of health problems Nurse Practitioners provide care equivalent to or better than Physicians and at less cost to the health care system.

Some individuals and groups have voiced concerns that in a time of limited budgets, the training of new health care providers may be imprudent. However, Nurse Practitioners will not bill OHIP (the Ontario Health Insurance Plan). Instead, they will be salaried health professionals working within a health care team.

The Ministry is recognizing the strength of the health care team in its initiative to train Nurse Practitioners. By creating an opportunity for Nurse Practitioners to enter the health care system, not in competition to, but in concert with doctors, The Medical Reform Group of Ontario sees the Nurse Practitioner initiative as an important step on the road to health care reform in Ontario.▼

General Meeting Debates...

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People at the MRG meeting by and large took a cynical view of the motivations for this sudden concern. No one seemed to doubt that cost-cutting was the real agenda, and that the aim was to reduce the number of insured services, not increase them. No government official is arguing that dental care and pharmaceuticals are medically necessary services which should be covered. Typical statements from government officials have been to the effect that some large percentage of medical treatments are of no proven benefit, the implication being that health care budgets could therefore be reduced by an equivalent percentage.

However, views diverged on whether, given this context, it was appropriate to attempt to define medical necessity. Some felt that without such a definition, provincial governments would be free to cut services as they wished, with no means to hold them accountable. Others felt that the effect would inevitably be to focus discussion on "what should be cut" while deflecting attention away from the issues which we feel should be discussed.

The evening's guest speaker, Philip Hebert, an MRG member who is on the staff at Sunnybrook and teaches ethics at the University of Toronto, suggested different ways in which one could attempt to define necessity, noting that very little literature exists on the topic. A key question, he suggested, is, Who gets to define it? Experts? Politicians and bureaucrats? Is the decision made democratically?

Philip suggested that it is appropriate to attempt to define medical necessity, arguing that it is better to have explicit criteria for deciding what our priorities are going to be, but adding that any definition has to be arrived at through a democratic process and has to leave room for professional discretion in its application.

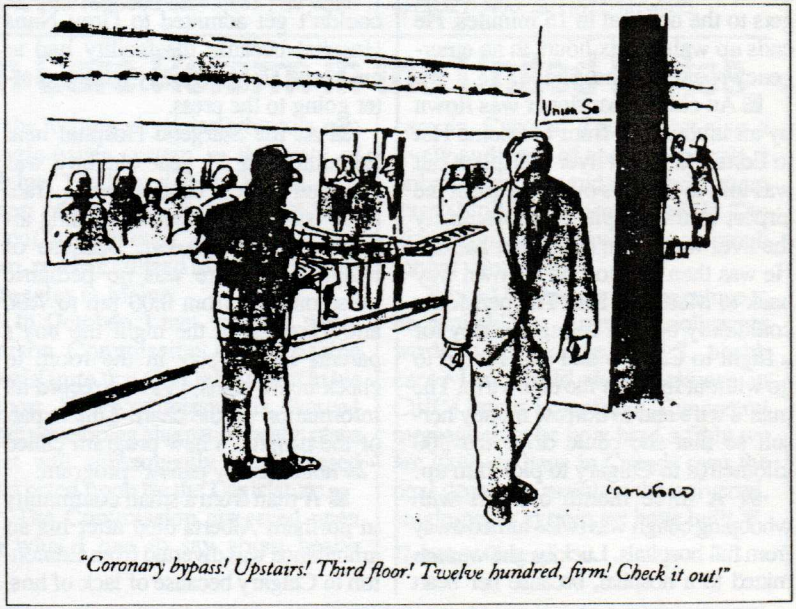
In the discussion which followed, members — whether or not they thought an attempt should be made to define medical necessity — repeatedly stressed the importance of not being trapped in a "what are we going to cut" debate.

Irving Brown said that we should be spending less time on deciding what is "in" and what isn't in. We should concentrate more on providing services *efficiently*, on cost *effectiveness* rather than *cutting*.

Haresh Kirpalani said that we have to ask where the rest of the cake is going, not just look at that portion currently earmarked for health care. For example, the real cost of producing expensive drugs is far lower than the price that is charged for them. Yet we don't talk about how we could reduce health care costs if we weren't providing the drug companies with massive profits. Birth weight is the key predictor of diabetes, heart disease, etc. Low birth weight is one of the main ways social class influences health status. Measures to ensure that pregnant women have good nutrition may not be "medically necessary", but would do much more to reduce future health care costs than cutting a few procedures here and there from the list of ensured services.

Ty Turner said that class is the major factor in determining whose needs get addressed by the health care system, but class is almost totally ignored by those who define the priorities for the system. Ty said that the reason he joined the MRG, and rejoined it after an absence of several years, is that he wants to be part of an organization which is very concerned about issues of equity and social class. We need to raise issues of social class, because no one else is doing it.

The full minutes of the fall general meeting are on page 16.▼



"Coronary bypass! Upstairs! Third floor! Twelve hundred, firm! Check it out!"

Quicker care is better care

The Medical Reform Group Steering Committee sent a letter to the Globe and Mail after that paper published an editorial suggesting that private clinics operating outside the publicly funded medicare system are a good thing. The following is the text of the MRG's letter:

The *Globe*, commenting on Health Minister Diane Marleau's declared intention to enforce the Canada Health Act in Alberta, questions whether private clinics constitute a violation of the Act (December 2).

The clinics charge a "facility fee" which buys quicker care for procedures such as cataract surgery or magnetic resonance imaging scanning than patients receive in public institutions. Quicker care is better care and no amount of wrangling about legal niceties can obscure the fact that private health facilities for the well-off violate the principles of the Canada Health Act.

The Globe defends private clinics because they relieve pressure on scarce public resources. That is exactly the problem. Events in the United States tell us that the poor do not have the political force to maintain accessibility and quality in a public system directed at their needs. If we put aside the Canada Health Act and allow the middle class to buy better care privately, the deterioration of public health care will follow quickly. As long as public health care is the only health care, and the privileged have no where else to shop, health care has a chance of withstanding the current budget-cutting mania. We must maintain the pressure for high-quality, prompt public health care.

Finally, the Globe suggests that clinics may be a more efficient way than hospitals to deliver some aspects of care. Quite right, and we should explore this option. However, the exploration and implementation must be done within a comprehensive national health care system that maintains the principle of universal access.▼

Gordon Guyatt, M.D.
Murray Enkin, M.D.
for the Medical Reform Group

Eight Alberta horror stories

■ A six year old boy's foot becomes caught in a lawn mower but he gets to the hospital in 15 minutes. He ends up waiting six hours in an emergency room and loses a toe.

■ An elderly pensioner was flown by air ambulance from Medicine Hat to Edmonton for a liver transplant but was told to find his own way from the airport to the hospital. Unfortunately the liver was given to another patient. He was then told to find his own way back to Medicine Hat. The pensioner could only borrow enough money for a flight to Calgary and was forced to go without food for the entire trip. The man's wife had to borrow money herself so that she could drive the 300 kilometres to Calgary to pick him up.

■ A three month old girl with whooping cough was twice turned away from full hospitals. Luckily, she was admitted to a hospital, because her heart stopped and she had to be revived.

■ A 21 year old with pneumonia couldn't get admitted to Grey Nuns Hospital because the facility had to cut costs. He was finally admitted after going to the press.

■ At the Sturgeon Hospital near Edmonton an 11 year old boy was admitted with a concussion, a fractured pelvis, and internal bruising after being hit by a car. Because of budget cuts there was no pediatric nurse on duty from 11:00 pm to 7:00 am. Throughout the night the boy's parents had to stay in the room to check neuro signs, IVs and record all information on the chart. This is part of the hospital's new program called "24 hour care by parent" program.

■ A man from a small community in northern Alberta died after his air ambulance was diverted from Edmonton to Calgary because of lack of hospital beds in the intensive care unit.

■ An Edmonton man had three fingers cut off in an industrial accident and rushed to the hospital only to wait 17 hours to have the surgery needed to reattach his fingers. He ended up losing the fingers.

■ A patient is admitted to a hospital and is taken to their bed only to find the bed had not been changed. The bed-sheets were still soiled from the body fluids of a patient who had died in the bed.

These stories were collected during August and September, 1994.

Reprinted from the November 1994 issue (Volume 9, No. 3) of Medicare Monitor, published by the Canadian Health Coalition, 2841 Riverside Drive, Ontario K1V 8X7, (613)521-3400, Fax(613)521-4655.

The Alberta experiment

The stories from Alberta are just the beginning of a health care system that has been forced into chaos and where the patient is the loser. The health care system has become an economic exercise where the bottom line is all-important. The public has just begun to feel what it is like in Klein's "new reality". A hard uncaring place where the sick, the elderly, and the unemployed are forced to bear the burden.

Ralph Klein will not succeed in his experiment. Support is high for his government now, but as the consequences of the across-the-board cuts sink in, his support will no doubt disappear.

Already there are cracks in his program as Klein criticizes the media and unions for publicizing the horror stories. Klein and his government have said that the isolated incidents have nothing to do with them. He has even gone as far as to say that the hospital workers may be putting people at risk to get headlines. The government quite simply does not want to be accountable.

Cuts to other departments will have a major effect on health. Over twenty-five thousand people have been cut off welfare. Without any money to support themselves some will move to other provinces but many will stay and suffer. The health care system will pick up a lot of the casualties from Klein's policies, with fewer resources.

The Alberta government believes that there is too much fat in the system. Their plan is to cut $700 million of the $4 billion health budget over three years. Unfortunately many of the cuts have not even been felt by the public yet.

Much of the government's dirty work is being done by the regional health boards who are announcing the cuts. Recently the health boards of Calgary and Edmonton announced hospital closures, thousands of layoffs, and reduced services. The chair of the Calgary board is quoted as saying "We will have an outstanding system in Calgary ... a model for other places when we are finished with it."

Unfortunately governments are looking at the Alberta experiment and if Klein is seen to get away with it then they will follow. We cannot let our social programs be damaged so severely they become worthless.

Our health care system helps define us as a country — how we care for and about each other as Canadians. For those of us who do not live in Alberta we may be breathing a sigh of relief that it is not happening in our province. Make no mistake we are all Albertans in this fight.▼

Kathleen Connors, Chairperson, Canadian Health Coalition

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The MRG and Health Care Reform in the United States

Over the past five years, one important area of MRG focus has been in helping with the struggle for a more equitable system of delivery of health care in the United States. We have forged important alliances, provided a great deal of education, and learned a lot. Our ultimate effectiveness can be summarized as follows: we've proved to be as capable of changing the U.S. health care system as is the President of the United States!

The accompanying article by Cliff Rosen reflects just how bleak the American situation has become. Cliff is the leading physician advocate of a single-payer system in the state of Maine. He has visited Canada as a guest of the MRG to learn first-hand about our universal, single-payer system, and has utilized MRG input in his struggles in Maine.

In October, I met with the three-person Commission of the Maine Legislature that Cliff talks about in his report. The Commission is charged with developing alternative health plans that will subsequently be discussed and acted upon by the Legislature.

The Commission appeared open to what I had to say about health care in Canada. There was also a lively audience of about 30 people. I only had an hour and a half with them due to limitations in my schedule. The discussion could have gone on much longer than that.

While I believe we must continue to be available to American colleagues working for justice in U.S. health care, I'm afraid the bleakness in Cliff's report is realistic. The central message may be how hard a fight we are likely to have in Canada over the next decade to maintain the universal, single-payer system we have built.▼

Gordon Guyatt

California dreaming: A Fall reflection from an American health care reformer

"All the leaves are brown and the sky is gray... California dreamin, California dreamin..."

Mommas and Papas June 1966

This article was written prior to the U.S. elections. The results of the elections confirm and strengthen the analysis in the article.

The turn to the right in the off-year elections in the United States has only served to further dampen hopes and expectations for dramatic changes in the American health care system. The inexorable eclipse of fall by winter reflects the tragic but widespread feeling that the AMA and the insurance lobby are just too powerful. The leaves of federal government reform have long since fallen.

However, many of us have been 'California dreamin' or believin' that the California referendum (initiative 186) which calls for a state-wide single payer system is our last best hope for universal coverage in the U.S. Undoubtedly, a positive vote on such a binding referendum (no legislative approval required) from the largest state in the union would have major ramifications across the continent.

But the state of California, with the ninth largest economy in the world, has not been forgotten by conservative groups interested in preserving the 'free market' approach to medical delivery. The same forces at work in Washington have now moved their successful lobbying efforts west. These organizations have outspent citizen action groups by 100:1 in their mammoth attempt to squelch a 'first-in-the-nation' single pay system. Polls suggest that this media blitz is having a profound effect.

Success in Washington has bred more 'Harry and Louise' TV advertisements this time for Californians. Nothing in America scares people more than telling them that the government is going to dictate how each person will get medical care. So, for those of us waiting with our fingers crossed, the California dream is turning into another nightmare.

Yet true to the nature of the seasons, this fall feeling will only be transient. New state-wide initiatives will rise from the ashes of the federal disaster. Like spring, legislative activity at various levels will be reborn. However, there is evidence that the battle will be even tougher than previous years. This is exemplified by the Maine experience.

In 1990, Maine activists, providers and legislators began to plan their strategy for a single pay system in the state. Support was widespread and insurance reforms almost came too easily. By the time a single payer bill (1992) was introduced, many believed Maine would be a great experimental proving ground. This sequence coincided with the national election of Bill Clinton.

For reformers, it was a heady time, a chance to choose the route to federal and state reform by: a) the McDermott Wellstone single-pay legislation; b) the Clinton plan with health purchasing cooperatives, managed care programs and the option for states to choose a single payer delivery system.

At the state level, Mainers were told that action was imminent, and that everything depended on the timing of congressional action. What followed is probably already known all too well by readers of this journal. The erosion of public support for the President and his wife coincided with a massive (100 million dollar) lobbying campaign from organized medicine, the insurance companies and many hospitals. The president refused to compromise on universal coverage, and his party supporters caved in to relentless lobbying pressure.

Reform moved from a major overhaul to a 'de facto' system initiated and controlled by insurance companies. Health care reform, as it was known, was in shambles. And those of us active at the state level were left holding the bag. What does the future hold? Will we be left with only a dream?

Maine is a very large but rural state of slightly more than 1 million people. Only three cities in the state have a population greater than 50,000. There are two tertiary care centres in the state, one osteopathic medical school, and four family practice residency programs. Currently there is a dramatic shortage of primary care physicians, both in the cities and in the rural areas.

Approximately 180,000 Maine citizens are without health insurance. Nearly double that are on Medicaid (the state sponsored program for impoverished citizens), and a very small

percentage of poor working Mainers are insured through a state program. Managed care plans and HMOs have rapidly penetrated the state. Blue Cross-Blue Shield, the major insurer of people in Maine, recently announced its intention to become 'for profit'. It has entered into managed care arrangements with providers in both the northern and southern part of the state. Its major competitors are the HMOs in the Boston metropolitan area (Harvard Community Health for example) and a physician run PPO (prepaid physician organization) called MedNET. Despite a state run commission that oversees hospital budgets and needs (MHCFC), health care costs continue to rise.

In the larger Maine cities, access is tremendously difficult not only for those without insurance but also for Medicaid patients. HMOs and PPOs have become lean and mean. Since Medicaid reimbursement is so low, the doctors and providers have banned new Medicaid patients from their practices. Worse, if a Mainer on Medicaid happens to already have been a patient in a group practice, that person would likely receive a letter sending them somewhere else.

Emergency rooms have few places to refer patients with Medicaid so they come back to the ER for their care. Specialists can and do refuse to treat patients on Medicaid leaving a number of people to travel 3-4 hours for specialized services such as ear nose and throat care.

Cost shifting by the providers continually pushes premiums up for those with insurance. Even those fortunate enough to have good insurance policies find themselves vulnerable not only because of the cost-shifting but also because their choice of physicians is strictly limited by PPOs, MSOs and HMOs. The current system is unfair to everyone! Yet, not only does it persist, it seems to be getting stronger. Once again, the American attitude that government is evil and that only through free enterprise can our health care system remain 'the best' prevails.

Maine is an ideal state for a single payer system. All the ingredients are there. More than 70% of the primary care physicians in the state supported the legislative initiative.

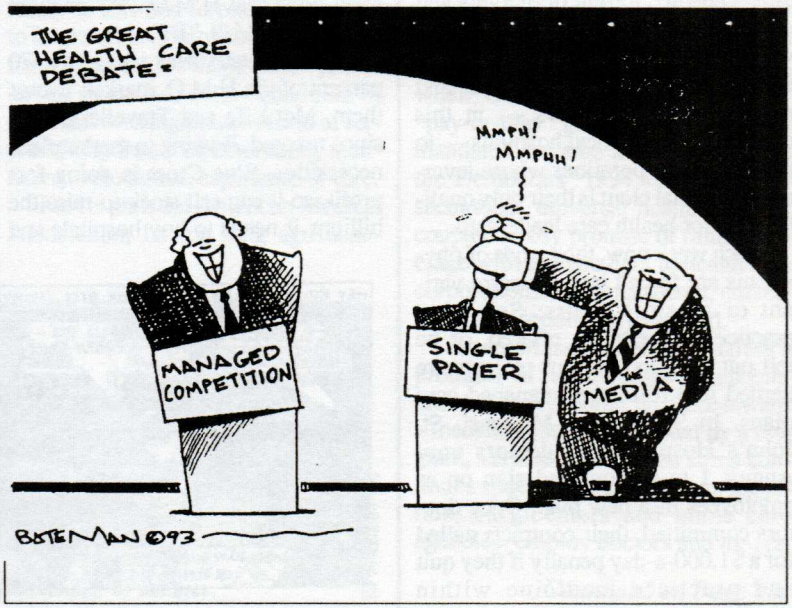
However, as soon as Clinton faltered, so did Maine's proposal. State legislators wanted to wait until the feds ruled. When they did not, most everybody claimed the issue was dead.

This left our state with a compromise (sellout) whereby a three member commission would develop three health care delivery systems from which the legislators and governor would choose one. Unfortunately, the Vermont experience already showed that the commission pathway does not produce meaningful reform. The once anointed single-payer state (Vermont) had their commission collapse under the weight of threats and innuendoes from providers and insurers. The chances that this will not be repeated in Maine are slim to none.

So, what is left is a de-facto system where administrative costs rise, consumer choice is limited, and universal coverage is but a dream.

Although the month of November heralds the onset of another harsh Maine winter, my fear is that it will also produce an even heavier burden for health care reformers like myself. With a conservative mood about to descend on this country, California dreaming may not be enough to carry us through to spring.▼

Clifford Rosen
Associate Professor of Medicine: Boston University School of Medicine and the University of Maine Department of Food Sciences



Galloping toward oligopoly: giant H.M.O. 'A' or giant H.M.O. 'B'?

The Washington health reform hoopla turns out to be a mere sideshow to the Clinton era's main event: the accelerating corporate takeover of health care.

Patients' care and caregivers' working lives will be poorer in 1995 than in 1985, and this will be the case even if Congress manages to squeeze out a me-too variant of managed competition. The extinction of both professionalism and medical altruism, and the depersonalization of care, not the legislative details of a paltry reform, define the medical context for this decade.

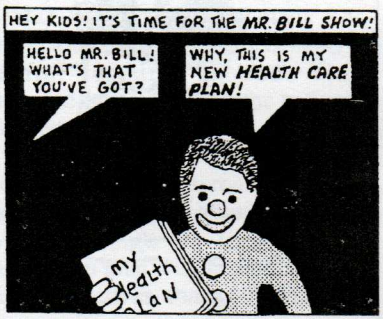
When, early on, Bill Clinton signaled that health care investors were safe on his watch — that for-profit H.M.O.s, private insurers and other health care businesses wouldn't just linger but flourish — he unleashed an unprecedented torrent of mergers and acquisitions. Never has control of so vast an industry shifted so rapidly from a dispersed array of small and medium-scale producers — in this case, doctors and local hospitals — to a few huge corporations whose leveraged financial clout is their only qualification for health care leadership.

Each week now, thousands of physicians are forced into a bizarre variant of musical chairs: Sell your practice on the terms offered, or be left out for good as your patients are herded into restrictive managed care plans. In Springfield, Missouri, St. John's Hospital gave doctors until August 1 to sell out and sign on as employees of a new plan. Once doctors committed, their contracts called for a $1,000-a-day penalty if they quit and practiced medicine within twenty-five miles of town.

The doctors' dilemma, in Springfield as elsewhere, is caused by the likely crash of medical practice outside the realm of managed care. H.M.O.s typically employ one physician for every 800 enrollees, but the United States has one doctor for every 400 people. Hence H.M.O. expansion absorbs many patients but relatively few physicians. When half the patients in a given region have signed on to managed care, only 250 patients per non-H.M.O. physician remain, too few even to pay practice overhead. Congressional guarantees of free choice in a fee-for-service option are meaningless; market forces insure that non-H.M.O. practice will shrivel, maintained only for an elite few able to afford astronomical fees. For most of us, the choice will be restricted to giant corporate H.M.O. "A" or giant corporate H.M.O. "B."

By 1993 ten firms controlled 70 percent of the H.M.O. market; two of them, Met Life and Travellers, have since merged. Bowing to marketplace necessities, Blue Cross is going for-profit, so it can sell stock to raise the billions it needs to buy hospitals and clinics for its own managed care networks. Pharmaceutical giants Merck, SmithKline and Eli Lilly paid $13 billion this year for firms that "manage" drug benefits, presaging the death of marketing through so-called drug detailing, whereby drug companies provide free trinkets and intensive mis-education to individual physicians. In its place: drug choices made directly by subsidiaries of the drug makers, with sales commissions (aka bribes) for pharmacists who lure patients to the desired brand.

The top ten for-profit hospital chains have been coupling like rabbits (though, unlike rabbits, each liaison leaves fewer firms, not more). In September of last year Columbia swallowed Galen; in February, H.C.A.; in July, it proposed the takeover of Medical Care America. Quorum acquired part of Charter last October, growing to 32,000 beds. American Healthcare Management and Ornda merged in April. Health trust bought Epic in May. And in most big cities, the non-chain hospitals are consolidating into a few giant groups. Under the guise of competition we've galloped toward oligopoly.



Meanwhile, as Congress debates coverage for the uninsured. the care of the insured is being transformed. The patient/doctor relationship is giving way to the employer/health plan contract. Managed care plans often force physicians and therapists to consult the plan's "utilization reviewers" (the insurers' representatives assigned to cut costs by limiting care) before discussing therapy with the patient, and then forbid disclosure of compromises on quality [see Suzanne Gordon and Judith Shindul-Rothschild, "The Managed Care Scam," May 16, *The Nation.*] G.E. employees in Boston are now forbidden to call their doctors for an appointment; instead, they must call a company reviewer, who filters requests. In California, Kaiser has told its primary care doctors that their patient caseloads have been increased to 2,000 (roughly double the typical number). The seven-minute doctor's visit becomes the norm, while health planners fret that there will soon be 165,000 unemployed doctors. Health plan administrators demand industrial "efficiency" at the level of each doctor/patient encounter, producing chaotic inefficiency for the health care system as a whole.

The new health care powers know finance, insurance, perhaps law — not medicine, or nursing, or cleaning bed pans, or patienthood. The new structure of care aims at profit, its new leaders are experts in that field. Why should doctors and nurses manage care; do chefs run McDonald's?

The Washington process that produced the Clintons' health plan is emblematic of the new structure. The policy experts and health management leaders have no medical or nursing knowledge, no clinical experience, no intimate encounter with illness. Hillary Rodham Clinton's task force of 500 included only a handful of people who had ever been to a hospital ward outside of visiting hours; most were too young and healthy even to have served as patients. It's no wonder they followed a script written by the Jackson Hole Group — a menage funded by insurers, convened by Nixon's health policy guru, Paul Ellwood, and guided by Alain Enthoven, Robert MacNamara's Pentagon protege who went on to a senior position at the military-contracting Litton Industries before sinking his teeth into health policy. The result, as Ellwood forecast: conversion to larger units of production, substitution of capital for labour and "profitability as the mandatory condition of survival" — a nightmare vision of for-profit, corporate medicine, utterly indifferent to the human experience of care.

For its part, the American Medical Association, having long ago abandoned patients' interests, has been so distracted by its fear of government that it barely noticed insurance company shackles snapping shut on its profession. The surgeons, quick to clamp a bleeder, were the first in organized medicine to react. The 53,000-member College of Surgeons endorsed a single-payer system this past winter; it's the only way to preserve their autonomy, and even jobs, as managed care plans whittle their specialist rosters. The conservative surgeons are strange bedfellows for the progressive docs who've rallied 6,000 strong to Physicians for a National Health Program, the Chicago-based group that put single-payer on the American medical map in 1989.

Soon the legislative details of whatever emerges from the bowels of Congress will fade to insignificance. Tens of millions will remain uninsured as promised savings from competition and managed care evaporate, and as government subsidies fall prey to budget-cutting. In Massachusetts (which is a world leader in both H.M.O. membership and health costs) more people are uninsured today than when Governor Michael Dukakis' "pay-or-play" plan, with its employer mandates, became law in 1988. Like the Democrats' 1994 versions, Massachusetts' universal health care bill coupled a rosy promise of future coverage with a green light to health care corporations. As costs soared, universality was indefinitely delayed.

As in Massachusetts, Congress's promises of full coverage are ephemeral, but the corporate advance toward a medical system dominated by a few giant, vertically integrated firms continues apace. Insurers will own hospitals, surgicenters and home care agencies; employ doctors and the rest

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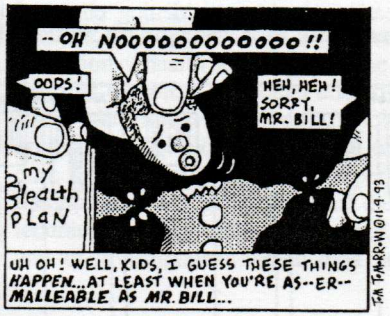

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of the medical work force; and perhaps merge with drug firms. For the insured, care will be defined by a deal struck between a corporate-care purchaser (i.e., your employer) and a corporate care deliverer.

In such a context, whither real health care reform?

In many areas of the country small-scale, fee-for-service practice is already dead or dying, foreclosing a purely Canadian-style reform for America. Once most doctors have become H.M.O. and hospital employees, breaking up these institutional arrangements would severely disrupt care. Resurrecting the Atlantis of mid-twentieth-century medicine is impossible. An anti-corporate, anti-market focus for reform is ever more germane. Corporate competitive imperatives are the palpable force destroying care. The managers and financiers who increasingly dominate care are not bad people (if so, we'd need only replace them); they're just responding appropriately to a system that demands misbehaviour: Put profits before patients or go under.

Mere opposition to corporate H.M.O.s is insufficient. We must devise their transformation. We need control by patients and caregivers, not stockholders, managers and employers. We need medical integration, so that health care in communities is not carved up among ostensibly competing organizations, each avoiding financially unrewarding tasks and patients, and shunning community-wide cooperation. We must scale care to a human size, so patients and providers can know one another and receive the care that is needed, not act as interchangeable corporate cogs. Unless H.M.O. physicians, workers and patients are centrally involved in planning this transformation, and in the movement for reform, it will surely fail. Recapturing the rational service orientation that characterized the original prepaid group practices (e.g., Group Health Cooperative of Puget Sound, a consumer-controlled cooperative, and even the early Kaiser, with its altruistic leadership and physician corps) can be revitalizing.

A public single-payer system *can* evolve from H.M.O.s and corporate care — if there's sufficient political pressure from a mass movement. Such a reform may share features with a national health service — salaried practice in integrated systems of care, with accountability to an electorate rather than to a corporate bureaucracy shaped by market forces.

The struggle over health care's future will continue. Immediately, attention will turn to the states. And even D.C. won't be quiescent for long. The immiseration of care and caring touches a widening circle of patients, doctors and other health workers, including groups that have been quite powerful until recently. Top-class care will be reserved for an ever smaller aristocracy, with 98 per cent of us relegated to factory-style medicine or worse. Even the local elites that have heretofore controlled local hospitals will be force-fed bitter pills, as national hospital chains and managed care plans take over. The constituency for opposition will necessarily broaden.

The strength of the single-payer movement has been, must remain, a clear vision of health care that is kind to patients, satisfying for caregivers and fiscally conservative. In contrast, Clinton's plan, even before all the compromises, was a prescription for corporate takeover. Few could, or should, rally to this banner. Clinton didn't try and fail. He refused to try.▼

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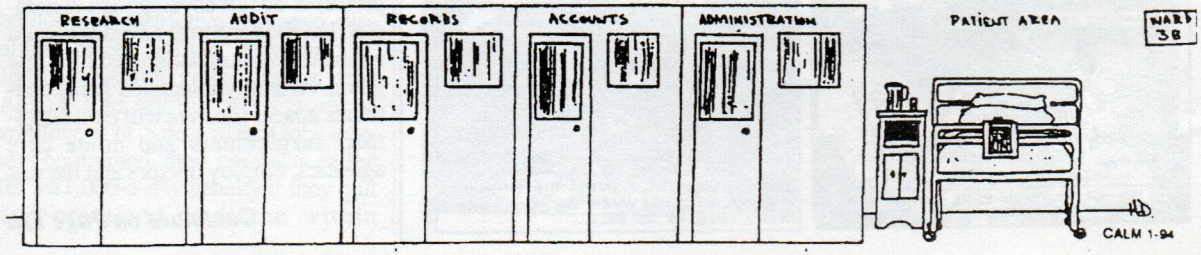

Forum on primary health reform

On November 11th, two members of the MRG participated in a forum on Primary Health Reform at the Ontario College of Family Physicians' Annual Scientific Meeting in Toronto. Michael Rachlis, co-author of *Second Opinion* and *Strong Medicine*, and Rosana Pellizzari, a member of the City of York Board of Health and of the Association of Ontario Health Centres, were members of a panel which also included Drs. Gary Gibson (moderator), Walt Rosser, and Wendy Graham.

The forum dealt with models of primary health care reform and the political context in Ontario. Three models were described: common features included patient registration, capitation-based blended payments, regional planning, electronic data collection to facilitate planning and evaluation, and a stronger partnership with population health/public health to address preventive medicine and the determinants of health.

Both Michael and Rosana stressed the importance of consumer participation through access to a community health centre model, governed by a volunteer community board, as an option which should be available throughout the province.

The obstacles preventing true reform are numerous: with an impending election, it is clear that a change in government could threaten any progress in primary health reform, especially since the Community Health Framework Project has still not made its public recommendations. Several strategies were discussed.

In addition, before any model is to be accepted or promoted by the heterogeneous medical profession, one of the most vocal and powerful stakeholders, an explicit discussion and debate of values inherent in any model must take place. Since primary care involves family physicians, among others, it was identified as a priority that the College of Family Physicians facilitate the development of a preferred model among its members. This, apparently, is already under way.

Although the most important stakeholder is the public, it was identified that health reform can be an intimidating topic. "We [Doctors] must be ethical and not use the public as pawns, as happened in the battle over extra-billing," warned Rosana Pellizzari. "And let us not be naive: in our criticism of the current problems in primary health care, let us not forget that we have much to be proud of, and much to protect." Dr. Pellizzari warned that opponents of a public system would appreciate help in creating the impression, for the general public, that the system has deteriorated to the point that the only way to "save" it is to allow privatization and an end to universality.▼

Note: for an in-depth presentation on one possible model for primary care reform, see Strong Medicine, by Michael Rachlis and Carol Kushner, HarperCollins, 1994.

WHO Definition of Health

Completely healthy, utterly unattainable?

"Health is not merely the absence of disease or infirmity but a complete state of physical, mental and social well-being." (World Health Organization definition of health)

How many times in how many essays have students reached for this definition of health, the better to open their assignments? It offers, the argument goes, a positive definition of health not a negative one. With its emphasis on mental and social dimensions it carries an implicit criticism of the biomedical model of cure not care, of professional expertise not lay community skills, of the technical fixes of drugs and surgery, and of investigations which look at parts (X-rays, urine and blood samples) not at the whole.

The critical look at biomedicine is certainly important. In that it mentions disease (rather than death from disease) it could be argued to redress some balance in favour of women since although women live longer than men they tend to suffer more ill-health during their lives. By includ-

ing the mental dimension it provides a means of breaking the taboo which still arguably prevents full and open public discussion of mental ill-health. And by introducing social aspects of well-being, the WHO definition could be said to offer the chance to refocus our thoughts (and hopefully actions) on to economic and environmental causes of ill-health. But this brings us to the first of several important criticisms of the WHO definition.

Because it is a global definition, it has to be all things to all people. Like many international agreements it is couched in sufficiently broad terms as to have many possible interpretations. The socialist might see in 'social' a call for an equitable distribution of income and wealth, and for co-operative not competitive social relationships. The liberal might on the other hand see little more than 'sociability', having good community networks, or indeed, simply making friends. The conservative could interpret 'social' as an issue of conformity — that it is healthy to conform to 'normal' (for which read conservative) values. In this definition 'anti-social' can then mean anything with which the conservative disagrees.

The second criticism is that the definition can be read as an invitation to debate what we mean by positive well-being. The difficulty with this is that it is only more affluent groups (whether inhabitants of the industrial Northern countries, or the middle classes within individual societies) who have the resources to engage freely in that debate. For others, the struggles for employment, family and shelter have, of necessity, to take priority. Since not all have the same opportunities to decide what constitutes positive health, the debate cannot be said to be genuinely democratic. The danger is then that what comes to be seen as 'positive health' only encompasses the views of the affluent white middle classes.

On the other hand, the 'absence of disease and infirmity' is much more clearly based on factors we can know about. We know that a poor diet undermines the immune systems of those with insufficient to eat and leaves them more vulnerable to infectious diseases. Thus the persistence of measles in developing countries; the return of diphtheria to Russia as liberal economies create new classes of poor; and the return of tuberculosis to the U.K. among, for example, homeless people.

We know many diseases are transmitted through infected water and poor sanitation. Thus the persistence of cholera in developing countries, and the increasing incidence of cases of dysentery in this country as we move from water as a right, free at the point of consumption, to water as a commodity, regulated by meters, with a positive disincentive to wash hands, clean food preparation areas or flush toilets. The WHO definition invites us to debate 'health' which we cannot know. But at the same time it invites us to play down 'absence of disease and infirmity' which we can know, and about which action, nationally and globally, could be taken.

The final criticism of the WHO definition concerns its apparent popularity with nurses, therapists and health promoters. Medicine, so the argument goes, is merely about establishing the absence of disease and infirmity. Nursing, therapy and health promotion seek to move beyond this and establish 'positive health'. But does this represent a convenient stick with which to beat the medical profession? Is 'health-as-a-positive' an occupational strategy to move nursing, therapies and health promotion out from the shadow of medicine? Is it a strategy to increase the status of these other health professions and health care professionals? If so, then perhaps we should regard 'positive well-being' with suspicion, for the professional middle-classes may have much more to gain from its adoption than those whose life pressures and lack of resources exclude them from the debate about precisely what well-being is. Time too, perhaps, to stop revering the WHO definition overall, and subject it to critical review.▼

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Cold hearts and coronaries

A large number of people currently employed in health promotion have to promote campaigns and activities which do not address the fundamental health problems in this country. Political pressure from the government, filtered through health authorities, is forcing many workers to spend most of their time trying to balance political expediency with sensitivity to public need.

A century ago, the early public health reformers were well aware that the basic requirements for a healthy population were warm, dry shelter, clean air and water, affordable nutritious and sufficient food and an adequate income. In the last 15 years we have seen the gradual erosion of these basic needs, increasing homelessness, frightening levels of pollutants in the air and in drinking water, and increasing food prices and declining incomes for the less affluent sections of this 'classless' society.

At the same time there has been a deliberate attempt to persuade the population that they have the main responsibility for their own health. There is very little that we can now do which is not attended by fear of death or disease or shadowed by guilt, whether it is going to the pub, having chips for tea or relaxing with a cigarette. There have been a few public voices raised against this 'victim-blaming'.

Political ideologies have come to dominate the delivery of health services and the tenor of health education in a quite unprecedented way, distorting the picture of public health and creating a climate in which informed people are afraid to speak out against what they know to be wrong.

Current campaigns supposedly aimed at the reduction of coronary heart disease illustrate some of the dilemmas which face those working in health promotion. These are: targeting disease or focusing on health; being concerned with quantity of life or quality of life; serving political masters or public need.

Attempts to reduce coronary heart disease by the strategies typically adopted in the past 15 years, that is by attacking 'lifestyles', are misguided and ill-informed at best and unethical cruel and cynical at worst.

There are well laid down criteria for campaigns aimed at the prevention of disease. These are that: the medical condition should be well-defined; the cause of the condition is known; appropriate intervention exists; compliance with control strategies is likely to be substantial.

None of these criteria are fulfilled in the case of coronary heart disease, which is neither well defined nor well understood. The diagnosis is a consequence of changing fashions in medical classification and came into existence only just prior to the Second World War. It covers a variety of problems involving respiratory organs and peripheral vessels as well as the heart itself. The cause of heart disease is unknown, although there are several 'risk factors', most of which are beyond individual control.

Few people understand that these risk factors are based upon statistical probabilities for the population as a whole or that their applicability to any one individual is highly uncertain. Moreover, reviews of combined research in the U.S. have shown that over a 10 year period, only about 10 per cent of men with two risk factors do go on to develop heart disease. Of those men who did develop coronary heart disease, 58 per cent had only one of the assumed risk factors or none at all.

It follows that appropriate intervention strategies are unknown. Those that have been tried have not shown notable success and the level of compliance with the prescriptions of health education is highly variable across groups, often short-lived and subject to misreporting for reasons of social acceptability.

The focus on individual behaviour as the major cause of death from heart disease cannot be supported by scientific evidence. But it is politically useful, acceptable to the medical profession and easy to grasp. In relation to diet, for example, the picture of fatty foods clogging up arteries as if they were drains has an instant if unpleasant appeal.

Unfortunately it is totally inaccurate, based as it is upon a misunderstanding of the operation of the digestive system. The latest research suggests that a low fat diet may be more harmful, since polyunsaturates oxidize more quickly and may result in thickening and scarring of arterial walls. A low fat diet is known to impair the physical development of children. Moreover, areas where the population has a high fat intake, such as Crete and the Netherlands, actually have a relatively low incidence of heart disease and a long life expectancy. Greece has one of the longest life expectancies in the Western world although smoking rates are among the highest. As for exercise, there is no evidence to show that exercising

regularly staves off heart disease because it is impossible to conduct controlled experiments.

The link between certain factors associated with the risk of developing heart disease and death from heart disease is composed of a separate set of possibilities. There are several stages leading up to death: predisposing factors, present from before or soon after birth, such as family history or infections in infancy; factors which increase susceptibility, such as economic and social strain, stress, smoking; factors which may precipitate a heart attack, such as accumulated stress, unemployment, a traumatic event; and factors which increase the likelihood of dying from an attack, such as social isolation, financial problems and speed of treatment.

There is no simple chain of events, where cause and effect are clear cut. Rather, heart disease mortality is a complex sociological phenomenon in which both political ideology and the dominance of clinical medicine play a major role in determining our view of reality.

The way we have been taught to construe heart disease has been influenced by a medical model which teaches that the target of treatment should be the individual. This approach may more or less work in relation to treatment but it is certainly less appropriate in respect of prevention, because it ignores the fact that ill-health is principally a group phenomenon.

It seems that certain disadvantaged groups in society become more vulnerable than others to a wide variety of breakdowns in health. This strongly supports a model of general susceptibility in which disease is a consequence of some groups being assailed by a set of strains associated with disadvantages at work, at home and in the wider environment. Whether individuals belonging to these groups will become heartsick or soulsick will depend upon a host of other background factors.

Targeting a medical condition of largely unknown and complex aetiology is expensive, ineffective and, some would argue. unethical. Moreover, it is cruel to expose people to conditions which make them ill and then blame them for dying. It is immoral to promise what cannot be delivered and to make people unnecessarily anxious in the interests of diverting attention from the fundamental inequalities which determine patterns of health and disease in this country.

Concern with quantity of life is distracting attention from quality of life. Far too many people live under conditions which make them frustrated, angry, dispirited, hopeless and disheartened. Heart disease is just one of many manifestations of the unequal distribution of resources in our society.

There is something seriously wrong with a society in which homelessness, poverty and racism are tolerated, even seen as normal, while smoking is regarded with horror. Smoking may well be an obnoxious habit but it is not nearly as harmful as sleeping in the street or a crowded bed and breakfast, living in constant debt in a cold damp house, going daily in fear of insult or assault, or facing a future devoid of dignity and respect.

There is also a certain anti-life element to the more self-righteous strictures of the self-appointed guardians of the public health. It is important to remember that the risk of death is increased by many things — war, traffic, high winds and jogging, for example. We were not designed for immortality and will inevitably die. Should life not then be enjoyable as far as is compatible with the human condition? As Margaret Drabble once wrote: 'The prudent are admirable but rarely attractive.'

There are worse states than a heart disease — a cold heart, for one, or worse, being totally heartless. Perhaps future Look after your heart campaigns should be directed at those individuals in positions of power nationally and locally whose heartlessness continues to damage the nation's health.▼

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Opportunity Knocks

New members are needed to join the MRG Steering Committee as we head into a year which promises to be full of challenging issues.

The Steering Committee meets once a month, with meetings alternating between Toronto and Hamilton.

Memberships on the Steering Committee can be a stimulating way of learning about the issues and challenges which are confronting the health care system (and those who wish to reform it in accordance with MRG principles). Previous experience is not required: all members of the Steering Committee were new to it when they first came on board.

If you are interested in volunteering for the Steering Committee, please contact a current member or call the MRG number at (416) 588-9167.

Leave well-being alone

'Oh dear. I don't like the look of this.'

'What is it doctor? Tell me!'

'Well, it's the results of the test. They are... er... rather unfavourable I'm sorry to say.'

'What test? What does it mean? What have I got?'

'It's the Well-being Test I'm afraid. You know, the assessment we took from you last week? I've just got the printout back from the lab. It says your level of well-being is **-27.3865**. In lay terms your well-being is about midway between 'moderately' and 'severely' deficient.'

'But I feel fine, doc!'

'Oh no. I'm afraid you can't possibly feel fine. I suspect you feel really rather awful. You do, don't you?'

'No. I don't as a matter of fact. I'm just great at the moment. I've landed this new part. I've moved in with Brian. Things are going well.'

'You will forgive me, but I beg to differ. Look at your WB profile. You never exercise. You're almost always up until the early hours. You drink. You smoke. You read philosophy. Frankly, you're riddled with angst... Look at you. You're 29 and you've never had a steady job. There's no sign of marriage. You move from flat to flat. All you've got is a few books, some scruffy clothes, and a guitar. And you're trying to tell me that you've got well-being?'

'Doc. I'm an actor. It's what I want.'

'Need I say more? There is hope, but it'll be touch and go. What you have to do is...'

Fantasy? Science-fiction? Out of the question? Not these days. Forget health promotion. Well-being is what really matters.

There are, admittedly, a few technical hitches to be overcome. There are certain prerequisites for the credible promotion of well-being: a workable theory, an understanding of the causal links between 'lifestyles' and 'well-being outcomes' and an objective means of assessment. None of which are currently available.

"...apparently you can be mistaken about your 'subjective' well-being whereas 'objective' well-being is a matter of fact"

But not to worry. An influential group of health promoters claims to know what 'well-being' is. They say they can distinguish between 'subjective' and 'objective' well-being (apparently you can be mistaken about your 'subjective' well-being whereas 'objective' well-being is a matter of fact). And that the way to ensure 'objective' well-being is to put in place the means for 'balanced' living.

Anyone who claims to know the components of 'objective' well-being is bound to offer a selective account of 'the good life'. The present trend is to say that (true) well-being is possible only for those who live in particular sorts of ways (for instance, for those who 'live moderately', who plan 'sensibly' for the future, and who uphold 'family values').

Such ways of life may well be widely commended, but they are very clearly not the only ways in which people can choose to live.

The argument that health professionals should seek to bring about well-being must be concerned with the ends of human activity. The trouble with this is that any specific account of well-being will inevitably be prescriptive about all human thoughts and actions (since all thoughts and actions must, in one way or another, have a bearing on an individual's goals).

It is immensely important to be clear about the implications of adopting well-being as the ultimate purpose of health care. It may well be that some people's lives are a waste. It may be that some people just get it wrong, and drift through life without ever finding a fulfilling path. Preventable 'cases' perhaps.

But 'bad life' prevention comes at too high a price. At a stroke the adoption of a theory of well-being legitimizes social judgements: you're a smoker, you're unfit, you take too many risks. For liberty's sake, health workers should leave the well-being of others alone.▼

David Seedhouse

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General meeting tackles "medical necessity"

Minutes of the Medical Reform Group's Fall General Meeting, held September 29 at the Davenport-Perth Community Health Centre in Toronto.

The Steering Committee Report was presented by Ian Scott. He reported the Steering Committee has been concentrating on building relationships with journalists and getting more media coverage. The newsletter, now in booklet format, is well-read — the feedback we receive tells us that it is being circulated in government offices and among members of the media.

Three new members have joined the Steering Committee since the last general meeting: Sonia Anand, Barbara Russell, and Ian Scott. A motion by Debby Copes, seconded by Haresh Kirpalani, that they be officially added to the Steering Committee, was passed unanimously. Haresh Kirpalani is leaving the Steering Committee after several years of service; Mimi Divinsky thanked him for his work on the Steering Committee and on the newsletter. Haresh said it was a very enjoyable and stimulating experience and encouraged other MRG members to considering serving a stint on the Steering Committee. Haresh will continue to serve as the MRG's delegate to the Ontario Health Coalition, with Rosana Pellizzari as the alternate delegate.

Financial and Membership: Haresh presented the financial and membership report. The MRG has run a deficit over the past two years. Expenses have been reduced while membership has held steady, but the amount paid per member has gone down appreciably, resulting in a shortfall of revenue. An appeal was sent out to members asking them to pay Supporting Membership donations on top of their regular membership fees; the letter also reminded people that membership fees are tax-deductible. Twenty-nine positive responses have been received to date; we are cautiously projecting a break-even budget for this year if people come through with their promised donations. We are also engaged in trying to raise the profile of the group and thus to increase membership. A motion by Ian Scott, seconded by Phil Hebert, to accept the financial report, was passed unanimously.

What does "medically necessary" mean?

Rosana Pellizzari introduced the evening's topic of discussion by noting that members of the Steering Committee are concerned that the hidden agenda behind the recent stress on defining "medically necessary" services may be that this is seen as a way to push cost containment without making it apparent that this is the goal.

She handed out copy of the H.E.A.L. (Health Action Lobby) discussion paper on defining comprehensiveness. The paper outlines current legislation in Canada, focusing on the Canada Health Act, which defines comprehensiveness as one of the five basic principles which are to govern the health care system. Provincial governments are required to provide "all medically necessary services", but "medically necessary services" are not defined.

The H.E.A.L. document recommends three steps, or "policy filters", to determine which services are to be defined as core benefits. These three policy filters are, first, Efficacy/Effectiveness, to be defined by health researchers; second, appropriateness, to be defined by policy advisors, and third, affordability, to be defined by the government. What emerges from these policy filters are the core benefits to be provided.

In a brief discussion of the H.E.A.L. position, it was noted that there seems to be little or no provision for democratic public input in this model.

Mimi Divinsky introduced the guest speaker for the evening, Philip Hebert, an MRG member who is on the staff at Sunnybrook Hospital and co-ordinates ethics teaching at the University of Toronto.

Philip began by noting that there is very little literature on what "necessary" or "medically necessary" means. Three questions we should ask when trying to define what is "necessary" are, (1) What is it?, (2) How do we come to know it?, (3) Who gets to define it? (Is the decision made by experts, or by politicians and bureaucrats, or democratically?)

Philip sketched his own conclusions, which are that:

(1) Defining medical necessity is appropriate;

(2) Necessity has to involve some notion of benefit; benefit has to be defined in a way that factors in considerations of urgency and best outcomes, and has to be defined in a way that is fair as regards claims to and need for medical services;

(3) A democratic process is important in attempting to define necessity, but is not without its own problems;
(4) Any definition of medical necessity has to leave room for professional discretion.

There are a variety of ways of defining necessary medical care, e.g., appropriate care, permissible care. Or we can approach it negatively, by defining it so as to exclude futile, useless, ineffectual, or frivolous care.

We need to ask, what is the purpose of medical care? What are its proper ends?

The twentieth century has been marked by therapeutic optimism and a technological imperative, leading to aggressive, strongly interventionist attitudes as to what care should be provided.

The World Health Organization's definition of health ("complete physical, mental and social well-being") is so broad as to potentially encompass everything.

There are limits to medicine. We cannot do everything. Rationing is pervasive and necessary. All systems develop mechanisms that ration services. The question is, on what basis are rationing decisions made? Rationing can be explicit or implicit (e.g. waiting lists, distance). We are seeing more rationing, rather than less, because people are living longer to die of more expensive diseases later in life, and a greater variety of more expensive treatments are available.

Yet there is poor evidence for the efficacy of most of the care we provide. If you don't have explicit rationing with explicit criteria for deciding when what services will be provided to whom, you get implicit rationing. In the United Kingdom, there is de facto rationing for dialysis on the basis of age, with additional discrimination against women, though nowhere is it explicitly stated that this is the policy.

Perhaps there is a moral virtue to hard (firm) budgets, i.e. a budget that sets an actual amount that can be spent on health care, or a particular type of care, because that requires us to make explicit decisions.

Jennett defines "appropriate care" as care that is suitable, successful, kind, safe, wise, and wanted by the patient. There are of course a lot of value judgements in all these definitions.

Brooks says that potential benefit should exceed risk by a sufficiently wide margin.

There is some maximal point of benefit beyond which benefit doesn't increase. E.g. length of stay.

Thurow suggests changing our approach from one of "do no harm" to "do only what will make a difference".

No matter how you try to define it, ethics and politics are inescapable. You can't avoid value judgements. These judgements concern the following principles:

1) Beneficence (harm vs. benefit). Making a decision on this basis requires patient input. It is interesting that patients are more risk averse than doctors, once they understand what the risks are.

2) Autonomy. What can patients ask for? Patients may choose less care. Patients must receive at a minimum the "standard of care" — legally guaranteed necessary care. Does this mean they cannot ask for more?

Difficulties with "necessary" care:
1) Problems of benefit
(a) What is reasonable expectation of net benefit? Who defines it? What is it? How do we recognize it?
(b) Priority — How much priority to we give to treating the sickest?
(c) "Best outcomes" vs. fairness/fair chance.

The over-treatment problem. Uncertainty is resolved by doing more: the patient asks for more, the doctor orders more.

Desperate remedies for desperate patients.

Lack of reliable outcomes for many interventions.

Efficacy data in randomized trials not same as effectiveness in actual practice.

(a) aggregation problem — large groups vs. small

(b) democracy problem — fair process only.

Discussion: In the discussion which followed, Haresh Kirpalani said that we have to ask where the rest of the cake is going, not just look at that portion currently earmarked for health care. The problem with the Oregon plan, for example, is that it applies only to the poor, and considers only the allocation of those resources arbitrarily designated as being for health care, rather than at society's resources generally.

Philip Hebert said that he agreed absolutely, but added that it is also a fact that doctors tend to overvalue medical interventions over other possible expenditures that have an impact on health. Any new technology that incurs a significant cost has to be evaluated before being introduced into general use.

Chris Cavacuiti said that we have to balance effectiveness against costs. For example, building bridges over train tracks would save a certain number of lives, but we (government) don't do it because of the costs.

Ty Turner cited the example of psychoanalysis, a therapy whose benefits are very uncertain, which costs $40 million a year. If those $40 million we shifted to major mental illness treatment, it is clear that the

money would be spent much more productively. Decisions are also being made at the governmental level. There is a desperate attempt by bureaucrats and politicians to download decisions to a lower level, using the rationale of moving it closer to the people. The effect of this may well be to diffuse decision-making.

Ian Scott said that *medical* necessity needs to be distinguished from *health* necessity; Rosana Pellizzari said that much public policy has an impact on health status; Ian added that factors like class and income have a real impact on health status.

Irv Brown said that a lot of things don't have to be expensive — they don't have to be provided by doctors.

Haresh said that the real cost of producing expensive drugs is **far** lower than the price. The massive profits of drug companies artificially inflate health care costs. Treatment could be provided much more cheaply. We should also remember that we are dealing with a class society. The cabinet minister and his wife and child will always get the more expensive treatment.

Birth weight is the key predictor of diabetes, heart disease, etc. Low birth weight increases the risk immensely. This is one of the main ways social class influences health status. This tracks through generations.

Mimi Divinsky said that as a family physician, she doesn't know what her job description is. Everything she does, someone else can do better. She gave a recent example from her practice in which her role was to phone the surgeon and get his agreement to allow the patient to remain in hospital another day so that support would be in place for her when she was discharged. The surgeon took her call, whereas he wasn't responsive to a non-physician.

Ty said that large groups of people get left out because they fall through the political slats. For example, women's mental health issues are being very strongly addressed at present, and women receive most mental health services. Some groups are unpopular and no one wants to touch them. For example, men with impulse control problems, some of whom have had brushes with the law. The mental health system offers them nothing, no one advocates on their behalf, and their route is to eventually end up in jail. This is an example of the major distortions that occur. Class is the major factor in determining whose needs get addressed, but class is almost totally ignored by all those involved in the health care system.

Ty said that the reason he joined the MRG, and re-joined it after an absence of several years, is that he wants to be part of an organization which is very concerned about issues of equity and social class. It should be our goal to seek the autonomy of the patient, and to give those of lower class origins as good an opportunity to get services as anyone else. We need to raise issues of social class, because no one else is doing it. We need a re-working of a class approach. We see advisory bodies and decision-making bodies monopolizing debate and decision-making. The people at the meetings of these bodies are always middle-class people, representing perspectives based on sex, sexual orientation, and ethnicity, but never class. No one represents working class or lower class people. The MRG should try to provide some corrective influence to this.

Rosana said that core benefits are a great way to have a two-tiered system. The well-off can get services not defined as core services, while they are not accessible to the rest of us. We need to ask: why are we discussing this now? Is this merely a rationale to implement cost cutting?

Ian said that he is worried that the agenda is to make the pot smaller.

Debby Copes said that we can't be cynical enough about the reason this is happening now. There aren't many things that are clearly of no benefit to anyone. A big part of the problem is allocating money by fee-for-service. We still have to allocate person-power and operating room time and drug costs.

Philip said that in the face of constant pressure to drag everything down to the level of dollars and cents, we need to remember that the purpose of health care is to contribute to human flourishing. A definition of an economist is someone who knows the price of everything and the value of nothing.

Mimi said that many things of proven benefit are not covered, such as drugs for poor people and dental care.

Irving said that we should be spending less time on deciding what is "in" and what isn't in; rather, we should concentrate more on providing services efficiently, on cost *effectiveness* rather than cost *cutting*.

Ian said that the socialized system is subsidizing de-listed services through costs of doctor training, infrastructure, etc.

Ty said we should oppose de-listing. When something is de-listed, an inequity is created because people with less money can't afford it.

Irving said that if it is useless, you can't forbid it (e.g. alternative medicine). Beneficial services should be available to all without cost, services of no benefit are outside the publicly funded health care system.▼

NEWS BRIEFS

Infant formula code violations

New claims have been made that Nestle and other infant formula manufacturers are breaking an international marketing code. According to the International Baby Food Action Network (IBFAN), Nestle and its competitors are still giving away free supplies in hospitals to hook poor mothers on their products. The marketing code was established by the World Health Organization in 1981. Monitors for IBFAN reported 107 instances of free infant formula supplies in hospitals in 28 countries, including Bolivia, Brazil, Chile, Indonesia, Pakistan, South Africa, and Thailand. Poverty and dirty water make expensive powdered substitutes for breast milk inappropriate and the code forbids free supplies to hospitals and direct promotion to parents. Babies can die from bottle feeding because poor mothers over-dilute the powdered milk and mix it with dirty water, causing malnourished children to contract diarrhoea, one of the biggest killers of infants in developing countries.

August 14, 1994

Snowbirds sue

The Canadian Snowbird Association, which represents senior citizens who travel south for the winter, has filed a suit against the Ontario government for limiting reimbursement to Ontario residents for out-of-country hospital stays. Earlier this year, Ontario's Ministry of Health announced that it was dropping its coverage to $100 a day from $400 a day. Under the Canada Health Act, payments for insured residents temporarily out of Canada are required to be made on the basis of the amount paid for similar services in their home provinces. However, Ontario, Saskatchewan, and Alberta each pay only $100 a day, while British Columbia pays only $75 a day for hospital stays by residents who are out of the country. The Snowbird Association says these rates are far below what these provinces pay for in-province hospitalization, the national average cost of which is about $550 a day.

August 17, 1994

Quality of care questioned

The quality of care in nursing homes is suffering as demands on a decreasing workforce escalate, says a survey of nurses carried out by the Ontario Nurses Association (ONA). The ONA study, "Staffing as a Quality of Worklife Factor: A Grassroots Approach", examined the relationship between staffing levels and the quality of worklife from the point of view of the nurses who work in 171 nursing homes and homes for the aged in Ontario. According to nurses surveyed, in some homes residents don't get all their medicines and treatments because there aren't enough nurses. Even such basic needs as nutrition are not always met, they said, because there are too few people to help the residents. Many nurses referred to an increase in dementias and increased violent behaviour, which they felt could be avoided if there was better staffing both in terms of numbers and education. The report offered four conclusions: 1) Participation in policy-making is not working even though a substantial minority of institutions have some kind of consultative body in place; 2) Problems are most severe in larger units where administrators seek to achieve economies of scale; 3) Nurses are afraid to express their real concerns for fear of losing their jobs, and are only prepared to speak out under the protection of anonymity; 4) Quality of nursing worklife and quality of patient care are inseparable.

Fundraising aimed at patients

Nova Scotia hospitals have been ordered to stop using lists of former and present patients in their fundraising efforts unless they first receive the patient's consent. However, the Health Department approved consent forms containing a clause that states that the patient consents "to receive information about making a charitable donation" to the hospital or hospital foundation.

Ontario MDs favour uses fees

A majority of Ontario physicians believe patients should be charged user fees for medical care, according to a recent survey. The Medical Reform Group responded by pointing out that "there is clear evidence that user fees hurt the sick and the poor."

August 17, 1994

Health care not legal right, lawyers conclude

A task force of the Canadian Bar Association has concluded that there is no legal "right to health care" in Canada. The law as it presently exists gives Canadians the right to publicly funded health insurance, but says nothing about what medical services will be provided under health insurance. Richard Fraser, who chaired the task force, called on the federal and provincial governments to draw up legislation that would enshrine a right to health care and define terms such as "medically necessary".

August 23, 1994

NEWS BRIEFS

MDs protest tobacco sponsorship

Physicians for a Smoke-Free Canada stepped up its war against smoking by protesting a tobacco firm's sponsorship of a women's golf tournament. The group decorated major roads near the Ottawa Hunt and Golf Club, home of the "du Maurier Classic", with signs declaring that "Cigarettes Kill Women". The signs were put up on the same poles as the banners promoting the tournament. The tobacco company is using the tournament to circumvent a federal ban on tobacco advertising, said Dr. Andrew Pipe, a physician at the University of Ottawa Heart Clinic, and a spokesman for the anti-tobacco group.

August 23, 1994

Hospital costs rise

The average per-day cost of caring for a patient in a Canadian hospital was $553 during the 1992-93 fiscal year, Statistics Canada reports. This represents a 6.8 per cent increase over the 1991-92 fiscal year. The figures include medical procedures, operating costs, and support services. Statistics Canada said the rise is in line with a steady increase in patient-care costs over the last decade. The inflation rate in 1992 was 1.5 per cent. Carol Clemenhagen, president of the Canadian Hospital Association, said patient costs rose because of increasingly complicated treatments and the requirements of caring for an aging population. There were 3.5 million admissions during the year, and the average length of stay was 12.5 days.

August 25, 1994

Blue Cross seeks new owners

Ontario Blue Cross, the largest provider of employee health benefits to Ontario residents, is searching for new owners. Blue Cross, a 650-employee not-for-profit company, is currently owned by the Ontario Hospital Association, which represents Ontario's 200 public hospitals. The company wants to expand and needs an infusion of capital, which the Hospital Association is not capable of providing. Blue Cross expects private spending on health care by individuals in Ontario to jump to $5.6 billion in 1997 from $3.6 billion in 1993, and wants to be ready to take advantage of the growing market for private health insurance as anticipated cutbacks to medicare take effect.

August 25, 1994

Anti-abortion harassment limited

The Ontario government has won an interim injunction against anti-abortion pickets at 18 locations, including doctors' homes and offices in London, North Bay, Brantford, Kingston, and Toronto. The judgement, which was less than the government sought, excludes anti-abortion protesters from picketing within 150 metres of the homes of nine doctors, within 18 metres of the Scott and Cabbagetown clinics in Toronto, and within 9 metres of the Choice in Health Clinic, also in Toronto. The Morgentaler Clinic in Toronto previously applied for, and was granted, a 150-metre exclusion zone. Abortion clinics in Ontario have been subjected to arson, chemical attacks, vandalism, death threats, and continuous harassment of staff and patients. Pro-choice groups said that the decision was a step in the right direction, but would not be enough to prevent harassment of patients and doctors. Anti-abortion activists vowed to find ways around the judgement.

August 31, 1994

Surrogate mother deals being made

A report by Canadian Press says that surrogate-mother arrangements are now being set up through several Toronto-area fertility clinics. In such arrangements, a woman agrees to become pregnant and to hand the infant over as soon as he or she is born. The going rate, according to the report, is $15,000 for the mother and $20,000 for the lawyers who draw up the contract. Such deals are not illegal in any province except Quebec, but the Royal Commission on New Reproductive Technologies recommended in its report last year that surrogacy deals should be outlawed. Dr. Peter Leung of the IVF Canada clinic said that his clinic has been involved in about half a dozen surrogacy arrangements so far. Dr. Mike Virro of the Markham Fertility Centre defended the practice, saying that surrogacy arrangements are not designed to make money but as a service to the infertile.

August 31, 1994

NB plans to cut workers' compensation

The New Brunswick government plans to cut employer contributions to its workers' compensation plan by an average of 18 per cent next year. The reduction in contributions was made possible because benefits to injured workers have been cut to 80 per cent of net pay for the first 39 weeks, from the previous 90 per cent.

September 1, 1994

NEWS BRIEFS

Parents sue over "wrongful life"

The parents of a boy with birth defects are suing their family doctor, saying the child should never have been born. The parents allege that a "wrongful life" resulted from a lack of proper medical disclosure of the mother's risk of giving birth to a defective baby. Jane and Robert Sanders say their doctor told them the results of a serum alpha fetal protein test were within the normal range. They contend that the results were abnormal, and that if they had been told this, the mother would have had an abortion. The baby has Down's syndrome and was born with a cardiac abnormality.

Arthur Schafer, director of the University of Manitoba's Centre for Applied Ethics, called the case "very thought-provoking", adding that genetic advances that allow prospective parents to determine whether a fetus has a propensity toward manic depression or early Alzheimer's disease create a potential moral powder key. "Will they choose to abort? Will the insurance companies be given this information?", he asked.

September 7, 1994

Blood shipments restricted

U.S. health officials have stopped some Canadian blood products from entering the U.S., after inspectors concluded that the way the Canadian Red Cross handles its blood products does not meet U.S. standards in certain respects. The shortcomings cited included computer software problems, sloppy record keeping and labelling, and substandard screening procedures for donors.

It was also revealed that plasmapheresis collection at four of Canada's 17 blood-collection centres was suspended briefly earlier this year while procedures were changed to meet new Canadian requirements.

After the reports were released, Federal Health Minister Diane Marleau ordered a review of blood collection standards.

Dr. Carlos Izaguirre, the assistant national director of quality and standards for the Red Cross, said his organization and the FDA have known for some time that the Canadian Red Cross didn't meet U.S. standards. "Our standards are not below standard," he said. "This simply reflects a difference in regulations between Canada and the United States." The decision stops the Red Cross from sending its plasma to the North Carolina plant where it is processed. There is no similar plant within Canada. About one-quarter of the Canadian plasma supply is affected, forcing the Red Cross to buy plasma from the U.S. to make up the shortfall. Stephen Vick, assistant national director of manufacturing and development at the Red Cross, also played down the report. "These are not safety issues, but differences in regulatory requirements that are largely technical," he said. "We have long said that we run a risk by having our products fractionated outside Canada. A fractionation plant will not only make us self-sufficient in blood products, but help us avoid the problems created by foreign regulation."

September 7, 1994

Psychiatric hospitals lose $53 million

Ontario's psychiatric hospitals are having $52.6 million chopped from their budgets during the current budget year and next year. Cuts announced recently range from 17 per cent at Lakehead Psychiatric Hospital in Thunder Bay to 10 per cent at the Queen Street Mental Health Centre and at facilities in North Bay and Whitby. Responding to expressions of alarm from the hospital and mental patients' advocacy groups, Health ministry spokeswoman Barbara Selkirk said that "everybody knew there were going to be cuts. They didn't know what their individual targets would be." The hospitals say they will have to cut program. Lakehead Psychiatric has already announced it will eliminate a program for seniors with dementia and a program for Alzheimer's patients.

September 7, 1994

Chiropractors battle pediatricians

Chiropractors have launched a counter-offensive against a group of pediatricians who want to put a stop to chiropractors treating young children. At a news conference called to respond to the pediatricians' criticism, Donald Henderson, president of the Canadian Chiropractic Association, accused the pediatricians of simply trying to create a monopoly in which only medical doctors can treat children. "This seriously libelled our profession," Dr. Henderson said, referring to a joint statement issued in September by the heads of the pediatric departments at 13 major Canadian hospitals. In that statement, the pediatricians called on the provincial government to stop funding chiropractic treatments for infants and children. The pediatricians said they felt compelled to speak out against those chiropractors who claim to treat a wide

range of childhood ailments including ear infections, colic, spinal scoliosis, tonsillitis, bed-wetting and asthma. Dr. Henderson acknowledged that some chiropractors may be doing things that are inappropriate, but said that they are very much a minority within the profession.

September 8, 1994

Companies evade WCB dues

Thousands of Ontario companies covered by the province's Workers Compensation Board are failing to make payments into the insurance plan by evading its registration requirements, according to a former WCB official. Alec Farquhar, appearing before an Ontario legislative committee, said that up to 20,000 companies are failing to make payments even though they are required to, at an estimated cost of $60 million a year. He also alleged that some employers are abusing the WCB's program of giving rebates for low injury rates by falsifying records. The WCB paid out $295 million in rebates to employers last year. Another $201 million was lost to employers' bad debts.

TB said to be spreading

Contradicting the statements of public health officials, some front-line health workers are saying that tuberculosis is spreading rapidly among homeless people in Toronto. Members of the TB Action Group (TBAG) said that the city's health department is moving too slowly in the early stages of what could become an epidemic similar to what is happening in New York City. Cathy Crowe, a nurse at the Niagara Health Services clinic, said that the health department should begin mass TB screening tests at hostels and other places frequented by the homeless, as well as among other high-risk groups like nursing home residents and prison inmates. "We've got all of the conditions that feed into the spread of TB — growing homelessness and cutbacks to the health care system," she said. The health department acknowledges concern over TB, but says that the number of active cases of the disease is remaining at close to 25 for every 100,000 persons in downtown Toronto. New York City, in contrast, reports 750 cases of TB per 100,000 persons. Howard Nojo of the health department said that mass screening might accomplish little more than wasting the health department's resources unless ways can be found to ensure that homeless persons attend follow-up appointments. However, Monica Avendano, a respirologist at West Park Hospital, said that contact tracing suggests that a surge in the spread of TB could be around the corner. "If we're not careful," she said, "we'll be looking at a potential epidemic like the one we're seeing in the States."

Planned Parenthood spotlights anti-abortion tactics

The Planned Parenthood Federation of Canada is urging supporters of abortion rights to be aware of tactics being used by the anti-abortion movement and to be prepared to counter them. According to Planned Parenthood, the tactics of the anti-choice groups include infiltrating feminist or pro-choice organizations; boycotting, picketing, and harassing companies and organizations which give money to Planned Parenthood; picketing banks and other financial institutions that provide loans to abortion clinics; picketing hospitals and family planning clinics; leafleting schools and door-to-door; forming "life-chains" at key intersections (people standing with anti-choice signs).

Report attacks fee-for-service

A report commissioned by the Conference of Deputy Ministers of Health has concluded that the fee-for-service method of paying physicians works against promoting good health. *Paying the Piper and Calling the Tune*, by McMaster University health economist Stephen Birch, says that fee-for-service penalizes doctors who take time with patients and doctors who take on people who are sicker and harder to care for. According to Birch, "Doctors who spend the time to make patients well can be penalized for that time. They perform fewer services, and so receive fewer fees. To move forward you've got to align the rewards to the providers with the objectives of the medicare system. That's not the case now."

September 25, 1994

Ambulance system criticized

Metro Toronto has wasted millions of dollars on a new ambulance computer system that has increased response times and places lives at risk, according to the chairman of a task force looking into the service. Dennis Fotinos called the new system "totally unacceptable" and said that Toronto would be better off going back to the old system. "We've spent millions of dollars on nothing," he said. The task force's report says that the new recording system has added as much as five minutes to the response time by requiring dispatchers to ask a compli-

cated series of questions before an ambulance can be sent. If a translator is required, response time can jump to as much as 25 minutes because the service must be accessed through a system located in California. Dispatchers reported that the new computer system loses calls for no apparent reason, and that the system was dispatching "ghost calls" to locations where ambulances had been sent exactly one year earlier.

September 27, 1994

Books says Rae gave in to drug firms

A new book by Queen's Park columnist Thomas Walkom says that Ontario Premier Bob Rae threw away millions of dollars in potential savings by secretly caving in the multinational drug companies seeking to block cheaper generic drugs. *Rae Days, The Rise and Follies of the NDP*, says that letters written over Rae's signature offering major concessions to the drug multinationals were partly written by the drug companies themselves. The New Democratic Party publicly portrayed itself as being adamantly opposed to the Progressive Conservative government's drug patent legislation, Bill C-91, which was passed in the House of Commons in 1992. In fact, Walkom says, the Rae cabinet had secretly capitulated in the hopes of attracting investment from the multinationals to Ontario. Rae personally promised the Eli Lilly company a two-year grace period for one of its patented drugs, Ceclor, to remain on the formulary of drugs approved under the Ontario Drug Benefit Plan, in return for the company promising to expand its Scarborough plant and create 150 new jobs. In doing so, he overruled his own health ministry, which wanted to delist a number of expensive patent drugs, including Ceclor, and replace them with cheaper generics. The book details several other instances where Rae is said to have intervened personally to ensure that brand-name drugs manufactured by the multinationals were kept on the formulary rather than be replaced by generics. The book records that the 150 jobs promised by Eli Lilly were never created.

September 28, 1994

Provinces boycott health forum

Provincial governments boycotted the first meeting of the federal government's National Health Forum. The provinces had asked that a provincial premier, Roy Romanow of Saskatchewan, be appointed co-chairman of the Forum with Prime Minister Chretien. The federal government refused, and the provinces responded by boycotting the Forum. The provinces say they are concerned that the National Health Forum is a cover for further cuts, and have said they won't participate unless they get a key role in directing it. The provinces pay for about $33.5 billion in health care costs, while the federal government provides about $15.6 billion through transfer payments. Federal transfer payments have been reduced year after year as a result of changes implemented by Brian Mulroney's Progressive Conservative government. The National Forum on Health is planned as a four-year consultation on the future of health care.

October 20, 1994

Fact finder to look at rural emergency

Ontario Health Minister Ruth Grier has appointed former deputy health minister Graham Scott as a fact finder to examine the problems surrounding service provision in emergency departments in small hospitals in Ontario. Scott has been asked to submit a final report by February 1995.

October 27, 1994

Radiation experiments were widespread

A panel appointed by the Clinton administration to investigate radiation experiments sponsored by the U.S. government between 1944 and 1975 has found that the experiments were much more extensive than previously believed. Experiments were conducted on more than 23,000 Americans in about 1,400 different projects, according to a study released by the panel. The panel has fully documented 400 government-backed biomedical experiments involving human exposure to radiation, and has received materials describing 1,000 other tests. U.S. researchers conducted several hundred intentional releases, in which radioactive substances were emitted into the environment, usually to test human responses and often without the knowledge of those exposed. The number of those involved cited in the report does not include those involved in tests sponsored by the Department of Defense or the Department of Energy, nor does it include those who happened to live downwind of the intentional releases but who were not studied for their reactions.

October 30, 1994

NEWS BRIEFS

Native health program

The Ministry of Health has announced a new aboriginal health policy for Ontario. The policy recommends ways to improve the health status of native people and improve access to health services. Its stated aim is to focus on "removing structural, cultural and geographic barriers to health care within the existing health care system, establishing a comprehensive network of aboriginal-controlled health services, and building partnerships between aboriginal and non-aboriginal providers and institutions." Ten new aboriginal health access centres offering primary care are to be funded under the program, as well as three hostels to treat aboriginal patients in Kenora, Timmins, and Toronto, and five new youth/family substance abuse treatment centres and healing lodges to provide residential and other forms of treatment. Aboriginal health authorities are to be established to support the planning processes of aboriginal communities and their interaction with district health councils. Native people die 10 years earlier than other Canadians, suffer double the rate of disability and infant mortality, and have up to five times the diabetes rates of non-native people in Canada.

November 1, 1994

Cold ads called a bust

The Ontario government's advertising campaign to keep cold and flu sufferers out of doctors' offices had no discernable results, according to a study by researchers at the University of Western Ontario. The $300,000 pilot project, conducted in London last winter, aimed at educating people to look after themselves at home rather than run to the doctor when they had a cold or the flu. The project was conceived after a study covering the first three months of 1991 indicated that 12.6 per cent of visits to doctors were for colds, at an estimated cost of $200 million a year. However, when the UWO researchers looked at 1,200 consecutive visits to family physicians during one week in January, they found that only 6.6 per cent were for colds, and that the average length of time a patient had waited before seeing a doctor was 9.8 days. "The majority of people don't go to a doctor unless their cold has lasted a long time, become more intense or developed into a secondary problem," said Dr. Evelyn Vingilis, director of UWO's health intelligence unit and one of the authors of the study. The study found that patient behaviour after the education campaign was not measurably different from patient behaviour before the campaign. Dr. Vingilis thinks that the high number of visits attributed to colds or flu in the 1991 OHIP study may be the result of doctors' billing practices. If a patient's initial visit is for a cold, the billing category is not changed even if the problem turns out to be pneumonia.

November 3, 1994

Vancouver doctor shot

Dr. Gary Romalis, a Vancouver gynecologist who performs abortions, was seriously wounded by a sniper hiding in his back yard. Police think the shooting was the work of an anti-abortion fanatic. Romalis, like other physicians who perform abortions, has been a target of frequent harassment and threats of violence. Anti-abortion protests have been held outside his home and office, nails have been scattered on his driveway, and the Romalis family received a threatening phone call the day before the shooting.

Kim Zander, a spokeswoman for the Everywomen's Health Centre, one of three free-standing abortion clinics in B.C., said the police are often slow in responding to protests in front on abortion clinics and observed that "it's not a surprise that what has happened in the United States would happen here. The anti-choice movement in the United States and Canada have very strong links." According to Dallas Blanchard, a Florida sociologist who has studied anti-abortion violence in the U.S., the common thread among those who resort to violence to oppose abortion is that they are all religious fundamentalists, "100 per cent of them."

Some anti-abortionists said that they did not condone the shooting, but others seized on the occasion to incite further violence. "This man is a mass murderer," said anti-abortion activist Christine Hendrix of Dr. Romalis after the shooting. "I do condone violence," prominent B.C. anti-abortionist Gordon Watson said. Some suggested that the shooting might have been a provocation to discredit the "pro-life" movement. "The pro-abortion movement in B.C. is made up of elements that I would not want to meet in a dark alley," said Ted Gerk, present of the Pro-Life Society of British Columbia. "They are angry and thus capable of almost anything." Ted Hughes, a spokesman for Campaign Life Coalition, said his group condemns violence, adding that doctors who perform abortions should expect violence because "the violence starts in the womb when all these human beings are killed by abortion."

November 8, 1994

NEWS BRIEFS

Taxation of health plans opposed

The private health plan industry is mobilizing to oppose suggestions that company-sponsored health plan benefits should be subject to taxation. Revenue Canada currently deems premiums paid by employers to be tax-free benefits, but the federal government has suggested that it might change the rules and the Commons finance committee has been looking at the issue. Members of the committee have suggested that the current system is unfair, since people not covered by a company plan — an estimated nine million Canadians — have to pay for additional benefits, such as dental plans, out of their own after-tax dollars if they want to have them and can afford them. Tax reform advocates like Ontario's Fair Tax Commission have also advocated that all income and all benefits, from whatever source, should be equally subject to the same tax treatment. However, health industry spokespeople say that the result would be that young healthy workers would opt out of the plans in droves, leaving older workers saddled with sharply higher premiums, while many employers would dismantle their plans entirely. "It will result in the disappearance of health plans as we know them today," Marg French of William H. Mercer Ltd., a benefits consulting firm, told the finance committee. "It will be a tax on sickness."

November 9, 1994

Marleau says she'll enforce Canada Health Act

Federal Health Minister Diane Marleau has renewed her threat that Ottawa will cut transfer payments to Alberta to punish the province for allowing private medical clinics to operate. "I continue to be concerned about the impact of private clinics and the ability of Albertans to receive medical services consistent with the Canada Health Act, particularly access to medically necessary services without financial barriers," Ms Marleau said. Ms Marleau said that the clinics siphon resources from the public system and result in low-income Albertans subsidizing the care received by the rich. One of the most prominent clinics, the Gimbel Eye Centre, collects $500 from medicare to perform cataract surgery on one eye, and then bills patients an additional $1,275. The Alberta government denies that this violates the provision in the Canada Health Act which prohibits doctors from charging more for a service covered by medicare than the amount set out in their provincial fee schedule, claiming that the fee is not for the service but a "facility fee". Ms Marleau previously threatened to take action on the matter in October of 1993, but appeared to back off when Alberta protested. The Medical Reform Group issued a statement calling on Marleau to enforce the Canada Health Act. (See *Quicker Care is Better Care*, p. 4)

November 1994

Hospital funds frozen

The Ontario government has frozen funding for Ontario's 221 hospitals for the 1995-96 fiscal year at the current level of $7.28 billion a year. Ontario Hospital Association spokesperson Beth Witney said she was pleased that funding has stabilized rather than being cut, but expressed concern that the freeze will mean problems for some hospitals, which will have to meet increases in costs for utilities, medical supplies, and other basics, without a matching increase in revenue.

December 7, 1994

Long-term care legislation passed

After a lengthy political battle, Ontario's new long-term care legislation has been passed into law. The bill will lead to a far-reaching overhaul of the home-care system. The 1,200 agencies which now provide services such as home nursing and meals on wheels will be amalgamated into 200 to 300 centralized organizations called multi-service agencies. The government sees the agencies as a way of streamlining the system, making it possible for those who require home care to receive them from one place, rather than having to find their way through the myriad of different agencies that now provide these services. The province, which currently spends about $645 million on home care, hopes that the reforms will lead to significant administrative savings. Several seniors' organizations supported the legislation, but many charities were strongly opposed. Lynn Moore, director of home-support services for the Canadian Red Cross, said that the government should have instituted pilot projects to test the viability of multi-service agencies. "The implications of what they are planning to do are so great," she said. "We need to be sure it works." District health councils will begin setting up the first multi-service agencies early next year.

December 8, 1994

NEWS BRIEFS

Nurse practitioners

Ontario Health Minister Ruth Grier has announced that training programs for nurse practitioners are to be re-instituted. Nurse practitioners may practise independently in isolated northern setting, but throughout most of the province they will practice as part of a health care team in settings such as community health centres. They will not bill OHIP on a fee-for-service basis. The Medical Reform Group issued a statement supporting the initiative as "creating an opportunity for Nurse Practitioners to enter the health care system, not in competition to, but in concert with doctors." (See *Support for nurse practitioners as members of health care team*, p. 1).

Agreement on Red Lake Emergency Department

An agreement has been reached between doctors in Red Lake and the Ontario Ministry of Health over the provision of emergency medical coverage in the community. Doctors in Red Lake withdrew 24-hour on-call coverage for the emergency department in Red Lake last spring in a protest over pay and working conditions. Under the new four-year agreement, the five Red Lake doctors will have their fee-for-service earnings converted into a global fund. The steady income will allow individual doctors to have more flexible office hours and maintain emergency coverage at the hospital.

December 14, 1994

Rosalie Bertel retiring

Rosalie Bertell, the driving force behind the **International Institute of Concern for Public Health** for the past decade, is retiring. The Institute is in the process of reorganizing and is looking for individuals with "new vision, fresh energy, and an impetus to push the community health agenda onto the nation's front burner." Contact the International Institute of Concern for Public Health at 830 Bathurst Street, Toronto, Ontario M5R 3G1, (416)533-7351, fax: (416)533-7879.

Social programs wrong target

A broad spectrum of organizations, including the Medical Reform Group, have endorsed a petition campaign sponsored by the Council of Canadians calling on the federal government to target corporate tax avoiders rather than social programs in its drive to reduce the deficit. An advertisement signed by many of the endorsing organizations, including the MRG, links the attack on social programs to free trade, which results is intense pressure on all countries to reduce their social standards to the lowest possible level. The ad states that large corporations are demanding deep cuts to social programs, despite the fact that only 2 per cent of the debt has come from social spending. Massive reductions in corporate taxes over the past number of years account for about 50% of the federal debt, while much of the rest is due to payments on the debt, themselves inflated by artificially high interest rates.

For more information about the petition campaign, contact the Council of Canadians, 251 Laurier Avenue West, #904, Ottawa Ontario K1P 5J6, 1-800-387-7177.

Regulatory Efficiency Act

The Canadian Environmental Law Association (CELA) is seeking to mobilize opposition to the Regulatory Efficiency Act (Bill C-62), which received first reading in the House of Commons on December 6, 1994. According to CELA, "The Act will allow businesses to be exempted from regulations under **any** federal laws by permitting them to negotiate private agreements with Ministers. These 'compliance agreements' will allegedly allow businesses to achieve regulatory goals 'through alternatives to designated regulations.' The Act is sweeping, applying to all federal Ministries and 'regulatory agencies' as well as to all federal Acts which may, together with regulations, be delegated to 'provincial, territorial and other governments or government agencies' for administration." According to CELA, the regulatory fields targeted for first action under the Act are health, food, therapeutic products, biotechnology, mining, automotive, forest products, and aquaculture.

CELA says that the bill "marks the end of any concept of general legal standards applicable to all, and puts in question all the public safety and environmental regulations that Canadians have achieved to date.... It will require that public interest advocates constantly repeat battles for standards that we have already achieved. Even monitoring these private 'deals' will place an impossibly heavy burden on the public." CELA notes that the government's stated rationale for this legislation is to help business get products to market more quickly, and to remove inefficiencies from outdated regulations. In reply, it contends that "if we have useless or outdated regulations on the books, we should revoke or amend them. We should not keep them in force to apply to some

people, and allow others to make private arrangements to avoid them."

CELA is contacting organizations concerned with environmental and health issues and asking them to lobby quickly against the bill, which the government plans to have in effect by the end of March.

Contact CELA at 517 College St., #401, Toronto, Ontario M6G 4A2, (416) 960-2284, Fax: (416)960-9392.

PUBLICATIONS

Enabling Biotechnology: A Strategic Plan for Ontario

A Report from the Biotechnology Council of Ontario, Station 1084, 8th floor, Metro Hall, 55 John Street, Toronto, Ontario M5V 3C6, 416-397-5301. 1994, 140 pp.
Analysis of and recommendations for Ontario biotechnology sector.

New Directions: Aboriginal Health Policy for Ontario

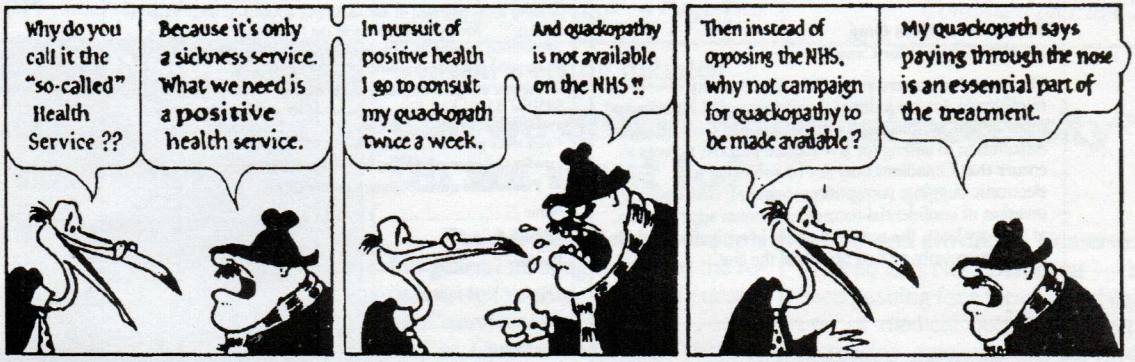
Ontario Ministry of Health, 8th floor, Hepburn Block, 80 Grosvenor Street, Toronto, Ontario M7A 1S2, 1994, 55 pp.
A report from the Ministry of Health whose purpose is to "provide the First Nation/Aboriginal communities and Ministry of Health with broad direction and guidelines for Aboriginal involvement in planning, design, implementation and evaluation of programs and services directed at Aboriginal communities."

Ontario Health Survey Mental Health Supplement

Ontario Ministry of Health, 8th floor, Hepburn Block, 80 Grosvenor Street, Toronto, Ontario M7A 1S2, 1994, 58 pp.
Contains selected findings from the Mental Health Supplement to the Ontario Health Survey. The principal objectives of the survey were to provide detailed information about the frequency and severity of various mental health disorders among the general population of Ontarians, and to document patterns of utilization of the formal and informal mental health care and support systems.

College Communique

The October 1994 issue of *College Communique*, published by the College of Nurses of Ontario, contains articles on nurse practitioners, with one article dealing with the regulatory framework to implement the nurse practitioner role and another article focusing on a "day in the life" of a nurse practitioner working as part of a health care team in a community health centre. Another article looks at the implications of three new acts passed by the Ontario Legislature: the Consent to Treatment Act, the Substitute Decisions Act, and the Advocacy Act. *College Communique*, College of Nurses of Ontario, 101 Davenport Road, Toronto M5R 3P1.



Health Service Wildcat is a new comic book from anarchist publisher Freedom Press, dedicated to 'the daft doctrine that people trained in making profits can provide a better health service than people trained in caring for the sick'. It is scripted by an NHS employee writing under the pen-name Victoria N Furmurry, and drawn by Donald Rooum. The book is available from: Freedom Press, 84b Whitechapel High Street, London El 7QX, price £1.95.

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3. Give financial support. Become a member of the Canadian Civil Liberties Association and/or make a tax deductible contribution to the public education and awareness activities of the Canadian Civil Liberties Education Trust.

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