# MEDICAL REFORM

Newsletter of the Medical Reform Group

Medical Reform Group, P.O. Box 158, Station D, Toronto, Ontario M6P 3J8 (416) 588-9167

Issue #94 — Volume 15, Number 1 — April 1995

## The determinants of health: How can we pay for them?

The Medical Reform Group's Spring General Meeting will be held on Wednesday May 3 in Toronto. Please note that this is a change from the previously announced date.

The meeting will be looking at two linked topics: the broad determinants of health, and the question of how we as a society can best allocate our resources to create the conditions for health.

The keynote speaker will be John Frank, who will talk to us about the broad determinants of health, and what we can learn from recent studies on the determinants of health.

After a question- and discussion period, we will look at a closely related question: how can and should they be paid for?

The meeting will be held at the Davenport-Perth Community Health Centre, 1900 Davenport Road, Toronto, and will begin at 7:45 pm. Dinner will be catered in, and will be at 6:45 in the same location. If you are planning to come to the dinner (and we encourage you to do so) please call 416-588-9167 by April 26 to say you are coming so we'll know how many dinners to order.▼

## OMA suspends negotiations with the government: Good Riddance

*The MRG issued the following media release on March 5.*

The Ontario Medical Association has suspended its participation in the Joint Management Committee (JMC), a bilateral committee the government and the OMA established to address health issues.

The effects of the JMC have, from the beginning, been destructive. The JMC has reinforced the disproportionate power physicians have in influencing health care decisions. Groups such as nurses, physiotherapists, social workers, health consumer groups and the general public have traditionally had too little power, relative to physicians, in influencing health care decisions. The JMC has made that power imbalance worse.

Solutions to health care problems will not come from closeted negotiations between physicians and government. Rather, they will come from open debate involving numerous groups working together. Of the various groups with a stake in health care decisions, physicians tend to be the most resistant to change. This makes the disproportionate power of physicians through the JMC even more problematic.

The OMA cited three reasons for suspending negotiations. The first is the cap on physicians' billing. The cap is necessary to limit costs in a public health care system under tremendous stress. The OMA says that because of the cap "a large number of doctors will be close to bankruptcy". While this statement is silly exaggeration, there is a problem. The cap has disproportionately penalized conscientious primary care practitioners who spend

*Continued on Page Two*

### INSIDE

## 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.

**Editorial Board:** Gord Guyatt, Ulli Diemer.

**Production** by AlterLinks (416) 537-5877.


**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.

### OMA suspending negotiations

*Continued from Page One*

extra time with their patients. It is the OMA, not the government, that has resisted the solution to this problem, which is to protect lower-billing physicians from the clawback.

The second reason the OMA cited was the government's failure to allow the doctors to incorporate. Incorporation would again favour high-billing physicians, and the government is making the right decision in not allowing this to happen.

The OMA's third reason is the government's failure to enact legislation to force third parties to pay for medical examinations which they require but which are not medically necessary. This might be a progressive step. If the OMA would ally itself with consumers' groups who, in this instance, share its interests, it might achieve its goal of forcing government action.

The JMC has been an undemocratic and unproductive bureaucratic structure. We call on the government to respond to the OMA pulling out of the JMC by abolishing the committee. As an alternative, government should bring together representatives of a variety of groups to work toward protecting universal health care and instituting positive reform in health care delivery.▼

# Ontario Medical Association's "Social Contract Days" Penalize Patients

*The MRG issued the following media release on April 5.*

The Ontario Medical Association is asking its members to withdraw all but essential health services for three days in April, and for one day in each subsequent month. The Medical Reform Group, an alternative voice of Ontario physicians, believes the OMA is acting irresponsibly in encouraging its members to withdraw services.

The OMA and the Ontario government negotiated a "ceiling" on government payments to physicians. For the 1994-95 fiscal year, this ceiling was approximately $3.9 billion, and for 1995-96 it will be $3.8 billion. Both the government and the OMA acted appropriately in setting the ceiling. Given the reductions in income, and job losses for every other group in the health care sector, it is necessary that physicians bear their share of the burden.

Physicians' billings have consistently exceeded the ceiling on which the government and the OMA agreed. As a result, the government has instituted "holdbacks" and "clawbacks" (in which a proportion of physician billings have not been paid) to keep physician payments from exceeding the ceiling. The OMA's decision to withdraw services is a response to the government's measure to enforce the ceiling on physicians' payments.

The MRG believes that physicians should not respond to the payment ceiling by reducing needed services, and thus penalizing patients. Since physicians remain by far the best-paid group of workers in the health care

# Sparks fly over call to lobby patients

The Medical Reform Group and the Ontario College of Family Physicians were at odds this winter after the president of the College sent a letter to MDs urging them to lobby patients to oppose the government's nurse practitioner initiative.

Writing to the College membership, Dr. Marilyn Spruyt, the College President, called for a "concerted effort" to marshall patient opposition to the nurse practitioner plan. Dr. Spruyt acknowledged that "this is not an easy issue to discuss in the context of an office visit", but nevertheless went on to say that "we believe that the patient/physician relationship is the key to 'mobilizing' the public on this issue."

The MRG Steering Committee issued a statement to the media condemning this call to bring politics into the consulting room, noting that "patients consult physicians when they are ill, and often frightened" and that "to use the patient/physician interaction as a forum for political lobbying is a breach of trust."

The MRG's response led to extensive media coverage, followed by a reply from the College. The College's letter, signed by Executive Director L. Cheryl Katz, said that the College agreed with the MRG that "Nurse Practitioners working in collaborative teams with Family Physicians can contribute to the primary care available in Ontario", but went on to raise a number of concerns about the present nurse practitioner initiative, including cost, administrative structure, and the government's failure to hold public hearings as required by the Regulated Health Professions Act. The letter avoided any mention of the subject of the MRG's statement to the media, namely that it is inappropriate for physicians to intrude a political agenda into a patient consultation.

This was pointed out in the MRG's reply, which urged the College to recognize the inappropriateness of physicians lobbying patients who come to them for health care.

The text of the letters and the MRG media statement appear below.▼

**Social Contract Days**

*Continued from Page Two*

sector, it would be reasonable for them to absorb an effective decrease in their fee-for-service payments.

Even more desirable would be implementation of a plan to reduce billings by more efficient delivery of health care services.

As well as unnecessarily penalizing patients, the OMA's chosen strategy will reduce physicians' credibility, and the public's trust. The profession can ill afford this loss of trust if it wishes to play an important role in the fight to maintain universal, high-quality health care for the citizens of Ontario. The MRG calls on physicians to not participate in withdrawal of services, and to lobby their professional organization to look for innovative ways of reducing expenditures by increasing efficiency of health care delivery.▼

## Family Physicians Group Encourages Unethical Behaviour in its Members

*The Medical Reform Group issued the following news release on January 16.*

The President of the Ontario College of Family Physicians is encouraging family doctors to take its battle with the provincial government into their offices. The College of Family Physicians opposes the Ontario government's plans to increase the role of nurse practitioners in health care delivery in Ontario. Dr. Marilyn Spruyt, the College President, has suggested that her members should lobby patients who come to them for health care and encourage these patients to support the College's opposition to the government's plans regarding nurse practitioners.

In a recent letter to the entire College membership, Dr. Spruyt states that "what is required is a concerted effort aimed at educating health care consumers, our patients, so they can voice their concerns" about Nurse Practitioners. "We appreciate that this is not an easy issue to discuss in the context of an office visit", she continues. "At the same time, based on feedback from our members, we believe that the patient/physician relationship is the key to 'mobilizing' the public on this issue."

Patients consult physicians when they are ill, and often frightened. Patients are dependent on their doctors, and vulnerable. They need to believe in their doctors' wisdom and integrity. For physicians to use the patient/physician interaction as a forum for political lobbying is a breach of trust. Dr. Spruyt is right that family physicians have considerable credibility with their patients. If they use this credibility to serve their own political interests with patients seeking health care,

*Continued on Page Four*

# College of Family Physicians responds to MRG media release

We have now had an opportunity to review the above-noted document [MRG Press Release, January 16, 1995]. It would appear that our organization is ad item with you and concurs that Nurse Practitioners working in collaborative teams with Family Physicians can contribute to the primary care available in Ontario. Indeed, in our communication with our members dated December 20, 1994 we support the delivery of primary health care by coordinated, interdisciplinary health care teams.

Our concern in respect of the Nurse Practitioner initiative announced by Ruth Grier is that licensing independent Nurse Practitioners creates a competitive environment which pits health professionals against each other rather than promoting the development of a integrated system with health providers complementing each others' skills and services for the benefit of patients/clients. It anticipates the creation of another bureaucracy, a more costly administrative structure and promotes the delivery of fragmented and duplicated care. Moreover, we estimate that the cost of this initiative exceeds 61 million dollars. These funds will have to be diverted from existing health services such as cancer treatment, palliative care, community and home support for those caring for disabled family members.

The Regulated Health Professions Act was developed over many years of consultation and work between the government and the Regulated Health Professions. This process was designed in good faith to integrate professional services and balance needs and resources. It allows for full and open debate regarding changes or additions in the scope of practice of regulated health professionals and requires that the public and providers be consulted whenever changes of this kind are proposed. This process is critical to protecting the public's interest in Ontario's health care system.

In this case the Minister is not following the law which requires public hearings and is circumventing the normal process of consultation. This would signal that duly passed legislation in Ontario can be circumvented at the whim of a health minister. It means that changes in scope of practice of any regulated health professional can occur without full and proper scrutiny.

The Ontario College of Family Physicians believes that it has an obligation to inform its members, their patients and the taxpaying public of these issues; indeed, it may be irresponsible not to communicate this information in light of the gravity of our concerns. Our intention is to promote informed discussion and open debate.

Our efforts to communicate our concerns about the impact of this initiative on the health care system will continue. Discussion and debate is healthy and democratic. It should be welcomed, not avoided. You may or may not agree with either our belief or our concerns. It is, however, inappropriate to articulate these differences as unethical.

Your press release was inflammatory and clearly designed to attract media attention rather than to discuss these differences in a professional and constructive manner. Under these circumstances, to suggest publicly that our President is acting unethically borders on libel.

As a community of physicians we trust that you will focus on the point of disagreement rather than using the media to launch what amounts to a defamatory personal attack.▼

**L. Cheryl Katz, BA, LLB,**
**Executive Director**
**on behalf of the Executive Committee**
**Ontario College of Family Physicians**

## Unethical behaviour

*Continued from Page Three*

they will discredit the profession, and deepen patients' mistrust of physicians.

The Medical Reform Group condemns Dr. Spruyt's attempt to use patients in the College's political battle with the government. The Medical Reform Group believes that nurse practitioners, working in collaborative teams with physicians, can contribute to health care in Ontario. Whether or not they agree with our position or that of the College, the Medical Reform Group calls on family physicians to resist the temptation to intrude political issues into the doctor-patient relationship.▼

# Doctor-patient relationship shouldn't be used for politicking

*Letter from the Medical Reform Group Steering Committee to L. Cheryl Katz, BA, LLB, Executive Director, Ontario College of Family Physicians*

Dear Ms. Katz:

We are writing in response to your letter regarding our January 16 media release. We agree with you that discussion and debate about health care issues, such as the nurse practitioner initiative, are healthy and democratic.

However, our news release was *not* about the issue of nurse practitioners, but about the use, or misuse, of the doctor-patient relationship. It is unfortunate that your letter makes no reference to this issue.

We believe that intruding a political agenda into the patient visit or consultation is a mis-use of a privileged relationship and is therefore unethical. You misconstrue our legitimate criticism of College policy as a personal attack on its President. This was not our intention.

We continue to stand behind our media release. It was factually accurate and in no way misrepresented communications from the College to its members. We believe that our disagreement with the content of the letter of December 20, 1994 constitutes fair comment on an issue of public concern. Holding the College's action up for public scrutiny and debate is a valid example of the discussion and debate which you correctly say is "healthy and democratic" and should be "welcomed, not avoided".

We hoped that by identifying the practice of raising political issues "in the context of an office visit" as inappropriate, we could prevent it from being repeated. If we, as professional colleagues, can agree that the office visit must be protected, then we should be able to leave politics where they belong: outside the examining room.

We urge you to clarify the College's position on the point at issue: the inappropriateness of physicians lobbying patients who come to them for health care.▼

Sincerely,

Mimi Divinsky, M.D.
Gordon Guyatt, M.D.
Rosana Pellizzari, M.D.
for the Medical Reform Group of Ontario

## GPs urged to fight nursing plan

### Reform body assails strategy of urging patients to complain

BY JANE COUTTS
Health Policy Reporter

TORONTO — The Ontario College of Family Physicians is urging its members to fight the provincial government's plan to licence nurse practitioners by lobbying, writing letters and pressing patients to complain.

In a letter sent out late last month, Marlene Spruyt, president of the college, asks her colleagues to use their "considerable credibility with many of their patients" to mobilize public opinion against the Ontario government's plan for deploying nurse practitioners.

The letter has raised the ire of the Medical Reform Group, which says it is unethical for family doctors to use medical appointments to win their patients' support for a particular political agenda.

Mimi Divinsky, a member of the informal organization that often takes issue with the actions of the medical establishment, said doctors who use medical appointments to advance their political agenda are betraying the physician-patient relationship.

She said that both doctors and patients are pressed for time, and that what takes place during a medical appointment should be dictated by the patient's needs, not a doctor's political concerns.

"If the patient raises it, that's one thing, but it is a misuse, a betrayal of the doctor-patient relationship, to ask people to support your political views when they are feeling vulnerable. . . . It is intimidating for them and they are not going to feel able to voice their own views."

In its letter, the college says the province's decision to licence nurse practitioners may fragment primary care and cost more money.

Nurse practitioners are to be trained to handle some aspects of primary health care, such as baby checkups and the monitoring of chronic but stable diseases such as diabetes.

But the family practitioners say that could boost the cost of the health-care system by increasing administration and duplicating services.

And the letter tells doctors to take action to spread the college's position — by writing their MPPs, talking to local media outlets and approaching patients on the issue when they come into the office for health care.

"What is required is a concerted effort aimed at educating health-care consumers, our patients, about the issue so that they can voice their concerns," the letter says, adding that "we appreciate that this is not an easy issue to discuss in the context of an office visit."

Reg Perkin, executive director of the College of Family Physicians of Canada, said in an interview that the letter went out in response to calls the college received from people concerned about the implications of the introduction of nurse practitioners to the province.

"The Ontario college [a chapter of the national organization] is quite responsibly trying to provide its members with information so when patients do raise the issue they have a response." He said the doctors want to stimulate public debate on the role of nurse practitioners — debate the college feels was cut off by the government.

Dr. Perkin said doctors should consider their relationship with a patient and the reason for the office visit before raising the matter. "Obviously, if you have someone in your office who is acutely ill, that's not the time to bring it up."

Gordon Guyatt, another member of the Medical Reform Group, said that "any right-thinking patient" will object to having a medical appointment exploited for political purposes.

While physicians often complain that they are given a bad image by the media, he said, "in this case it is doctors making doctors look bad."

# Incorporation for Ontario Physicians?

*Members of the Medical Reform Group Steering Committee have written a draft policy on physician incorporation, together with a fact sheet on the issue. MRG Members are invited to comment on this issue, and this draft position paper, by sending their thoughts to* ***Medical Reform****.*

The Ontario Government, wielding its social contract cutback knife, has been relatively sparing with physicians, society's highest paid professional group. The government has insisted on a global cap for physicians billings which has resulted in withholding less than 3% of physicians' health plan billings. Now, the Government is considering allowing physicians to incorporate. Incorporation would allow the average physician in Ontario to increase their after tax income by $20,000. This saving for physicians will cost the citizens of Ontario as much as $75 million per year. The Health Professions Regulatory Advisory Council (HPRAC) is recommending against incorporation of physicians and other health professionals.

The central question in this debate is: should the government, in a period of constraint which has led to major social welfare cuts, permit tax advantages to some of the most privileged members of society? Once again the economically elite escape their social contract with society while the less powerful are victimised. The Medical Reform Group of Ontario joins with the HPRAC in strongly opposing incorporation of all health professionals.

## INCORPORATION FACT SHEET

### The Agreement

It appears that an agreement was made between the Ministry of Health and the Ontario Medical Association. It may be difficult to argue that collective agreements should be broken under any circumstances. Our opposition should be clearly not against the enacting of the agreement but rather to the Provincial Government for negotiating such an agreement in the first place.

Schedule 9 of appendix 3 of the Interim Economic Agreement between the Government of Ontario and the OMA makes reference to an agreement on the incorporation of Physicians. The text of this agreement on incorporation is as follows:

*"The Government agrees in principle to incorporation for Physicians, and in order to implement this agreement in principle, to introduce and support appropriate legislation, and to request Royal Assent following the third reading, in accordance with the following action plan:*

*a) Upon the signing of this agreement, the Government shall consult with the OMA with respect to the appropriate text of recommended amendments to the Medicine Act, 1991 for the purpose of giving effect to the agreement in principle to incorporation for physicians. The text of such amendments shall be included in the referral described in (b) below;*

*b) The Minister of Health agrees to refer the issue of the nature of the amendments required to provide rights of physicians to incorporate, together with the questions of the right of other health professionals covered under the RHPA, within 30 days of the RHPA being proclaimed in force;*

*c) The Minister will request the Advisory Council to provide its advice not later than ninety days after the Referral has been made to it;*

*d) Within six months of receiving the advice of the RHPA Advisory Council as provided for in (b) and (c) above, the Government shall have prepared, including Third Reading, and requested Royal Assent to legislation providing for incorporation for physicians."*

Advice from the Health Professions Regulatory Advisory Council (HPRAC) was sought by the Minister of Health, Ruth Grier, in January 1994.

The OMA claims that the interim agreement stipulates that the HPRAC is required to comment on the nature of the amendments required to the Medicine Act of 1991 to allow physicians to incorporate.

The letter from Ruth Grier to the HPAC which included the above passage. This letter requested advice in the following domains:

- Policy implications and policy development;
- Principles;
- Questions related specifically to the amendments;
- Questions related more generally to the issue.

The HPAC conducted a public forum, invited written submissions, looked to other jurisdictions which allow physician incorporation, obtained technical opinion related to tax related issues, and conducted 10 interviews to clarify received written submissions.

**The HPAC concluded that:**

Incorporation of any regulated heath profession is not demonstrably in the public interest.

Incorporation of any health profession is potentially contrary to the public interest on a number of grounds.

The government should not proceed with permitting the incorporation by any regulated health profession.

### The Public Interest

Other businesses are allowed to incorporate but health care professionals are not like other businesses in that the purpose of health care is service not profit maximisation.

Those professionals who leave Ontario for other jurisdictions where incorporation is allowed would be motivated exclusively by profit.

Do we permit tax advantages to some of the most privileged members of society in a time of constraint (federal budget etc.)

The advantages realised by the profession would be unequal within the profession, benefiting the highest billers in the system.

Incorporation could entrench the fee for service system and may discourage health reform.

### Cost

Physicians who incorporate would see a reduced combined tax rate drop from 44.2 to 22.3 per cent on their first $200,000 of income. For those earning $100,000 no savings would be realised. For those earning $200,000 a year a saving of $4,700 would be seen, with those earning $300,000 a saving of $9,000 would be seen. An administrative fee for incorporation is estimated to be $2,500 which would reduce the above savings.

Incorporation could cost the public as much as $75 million a year. This cost could be much greater since fairness would necessitate other regulated health professionals being allowed to incorporate.

### Liability

Practitioners may be able to shield themselves from actions arising out of negligence in the provision of professional services behind the corporate structure. Limited liability is intended to allow that only the dollars invested by a shareholder are vulnerable in the event of an action against a business.

### Ownership

Payments for physicians (OHIP) are made to individuals and such individuals are monitored and may be referred to a medical review committee. If payment is allowed to incorporations, the Ministry would be handicapped in its ability to monitor and recover payments from individual physicians.

### Regulation of the Health Professional

Colleges must have the authority to regulate their members. The increased complexity of the corporate structure may impede the capacity of regulatory bodies to monitor and discipline its members.

The CPSO does not find incorporation objectionable as long as the government's proposals do not allow corporate structure to place a barrier between physicians and itself.

The ownership of a "doctor" corporation is problematic and could raise a number of ethical as well as legal problems according to the CPSO. For instance, the Business Corporations Act states that a shareholder's primary responsibility is to the company, whereas a physician's primary responsibility should be the patient.▼

# Public health services are essential services

*The Medical Reform Group sent the following letter to Toronto City Council to protest proposed major cutbacks to the Department of Public Health budget.*

Dear Mayor Hall, members of the Executive Committee:

We understand that the Toronto City Council is considering major cuts to the Department of Public Health. These cuts are likely to mean reductions in dental services for welfare recipients, decreased pest control services, decreased tuberculosis prevention, and cuts in nutrition services, as well as reductions in other services.

As a physicians' group, the Medical Reform Group is very concerned about the adverse effects on the health of Torontonians which will result from these cuts. We believe that these public health services are essential services and that the proposed cuts are extremely retrogressive. Not only do the proposed cuts ignore the human suffering that will result from the increased burden of illness, visited largely on the disadvantaged, but they are fiscally short-sighted. Decreased health of Canadians reduces productivity, and places additional burdens on the publicly financed health care system. By saving money now, we are ensuring that there will be increased and unnecessary costs in the future.

We therefore express our strong opposition to cuts in the budget of the Department of Public Health, and urge you to reconsider this proposal.▼

**Medical Reform Group of Ontario**

# Aberman, Rachlis face off over Ontario health-care funding

**By Pat Rich**

Whether Ontario should follow the lead of Alberta and British Columbia in allowing private magnetic resonance imaging (MRI) clinics to operate in the province was the main focus of a high-profile debate on health-care funding held here recently.

Dr. Arnie Aberman, dean of medicine, University of Toronto, favors private facilities, while health consultant and author Dr. Michael Rachlis said such initiatives should not be allowed.

An auditorium packed with medical students and some prominent University of Toronto medical school professors were on hand to hear the two doctors debate the need for increased private financing of Ontario's health-care system — an issue on which the audience indicated it was evenly split.

The debate was the inaugural event for the health-care issues committee, formed by University of Toronto medical students, who plan to send a video of the discussion to the other medical schools in the province.

Speaking first, Dr. Aberman limited his proposal to privately funded medical clinics providing uninsured services for those who do not want to use the public system.

He said private clinics would increase access to medical services and would allow the government to concentrate on medically necessary services. The move would provide employment for those in the health-care sector and would help establish new technologies and procedures.

By shortening the waiting lists for services such as MRIs, Dr. Aberman said, access to medical services would improve for the poor and disenfranchised in the public system.

Although Dr. Rachlis is against injecting private funding into the system in general, he responded specifically to Dr. Aberman's call for private clinics.

Dr. Rachlis said private clinics allow those with money to get the services they need, removing their "voice" from those demanding reform of the health-care system. Because of this, he said, it is inevitable the public system will deteriorate and the have-nots will face poorer quality of care.

Asked later how removing those willing to pay for private clinics from waiting lists within the public system could do anything but benefit that system, Dr. Rachlis responded the increased access created "would last about 10 minutes."

He said arguments to allow private funding into the system are actually calls for more money to be spent on health care as a whole. This money should be invested in other parts of the system, such as schools and roads, he said.

Overall, Dr. Rachlis said, all methods of private funding — from user fees to taxbacks of health benefits — inevitably benefit the rich and hurt the poor. Because Canadians have enshrined equity as a major goal of the system, there should be an effort to maintain equal access to health services.

Dr. Aberman called this viewpoint "theoretical and fanciful." He said that despite cutbacks in the system, "those who are powerful and wealthy today get all the health care they want."

During question period, University of Toronto health economist Dr. Raisa Deber (PhD) challenged Dr. Aberman's statement that there is more economic utility in letting people privately buy health care, rather than having them spend that money on something else. She said medical services cannot be viewed as a commodity in the same way as clothing or housing; and that it cannot be assumed someone would choose to have an MRI scan in a private clinic rather than spend the money on a vacation.

Asked to vote on whose side they supported at the end of the debate, a show of hands indicated Dr. Rachlis' view opposing private funding was the clear winner in contrast to the even split that existed before he and Dr. Aberman presented their arguments.▼

*This article appeared the February 28, 1995 issue of The Medical Post.*

# Maintain the principle of equal access regardless of income

*The Medical Reform Group's Steering Committee sent the following letter to the Globe and Mail after the Globe published editorials attacking federal health minister Diane Marleau for penalizing provinces that permit user charges.*

Diane Marleau has acted with courage and integrity in insisting that provincial governments maintain the principle of universal access to health care. She has acted wisely when she has informed provincial governments that they will be penalized for allowing user charges, including private clinics. British Columbia has responded appropriately in resolving to comply with the federal directives.

In contrast, in a series of editorials attacking Ms Marleau, the *Globe and Mail* has joined the ranks of those conducting an assault on the principles of Canadian national health insurance.

What the *Globe*, in its editorial of January 11, characterizes as "hoary philosophical grounds" is nothing less than the principle of equal access to high quality care regardless of income. When we tolerate health care in private clinics for those who can pay, we are permitting two-tiered care. When governments subsidize such clinics with public dollars, they are actively encouraging the destruction of equal health care for all Canadians.

The *Globe* editorial suggests that private clinics can save money. The experience in the United States, which spends over 14% of its gross national product on health care, in comparison to less than 10% in Canada, shows us the fiscal consequences of two-tiered health care. A universal, single-payer health system is the most efficient way of delivering medical services.

Further, the *Globe* suggests that private clinics, by siphoning off some patients, can improve service in public facilities. Both health personnel training and medical technology development are funded from the public purse. Private clinics drain these resources, and thus weaken the public system. Private clinics do indeed provide an escape valve, but its effect is to reduce the pressure to maintain high quality public health services.

The call for a two-tier system comes at a time when the *Globe and Mail*, along with a number of other powerful voices, is advocating a cut in social expenditures, including health. Those with higher income who have the strongest political voice in our country will benefit most from a two-tiered system and governments will have little incentive to maintain the public tier that most Canadians use. If those with privilege and political power much seek health care within the public system, governments will find a way to ensure continuing high-quality care within that system.

Congratulations, then, to Diane Marleau for working to save a magnificent system under intense threat.▼

# Ensuring a healthy Canada: Where should the money come from?

*The following position paper represents the work of MRG Steering Committee members and is being put forward as the basis for an MRG policy statement. Members of the MRG are invited to come to the Spring General Meeting on May 3 to discuss the issues raised in this paper, and/or to send their comments to* ***Medical Reform****.*

The national pre-occupation with government deficits, and the tremendous resulting pressure on public expenditures, presents a challenge to the Medical Reform Group. To what extent should we resist reductions in health care expenditures? Should we take a stand on reductions in other expenditures? If we resist reduced spending, how should we reply when asked, "From where will the money come?"

This document presents the MRG Steering Committee's tentative answers to these questions. To an extent, it would represent a new evolution in MRG policy. As a result, the Steering Committee needs the input of the membership to ensure we are going in the right direction.

## Can we reduce health expenditures?

First and foremost, we must maintain our unequivocal opposition to user fees. User fees tend to increase, rather than decrease, total health expenditures. They decrease health care utilization by those who need it most (the poor are less healthy than the economically privileged) and place financial burdens on the sick (again, disproportionately, the poor). User fees will inevitably result in better health care for the well-off, inferior health care for those who cannot pay.

Any reduction in health care expenditure must therefore either be accompanied by increased efficiency, or result in a reduction in the quality of health care for all Canadians. The MRG believes that health care can be more efficient. We envision a restructuring of the system to a capitation-based system of primary care, with salaried, hospital-based secondary and tertiary care. Another major source of savings can come from reducing unnecessary investigations by reducing the incentive for physicians to order tests, and by educating physicians in their optimal use.

These increases in efficiency will not follow from simple cuts in health care budgets. We have seen that budget-slashing without plans to increase efficiency leads to arbitrary reduction in effective and cost-effective services. We therefore oppose overall cuts in health care spending that are not accompanied by plans to increase efficiency, and thus maintain or improve the quality of health care.

## Can we reduce social expenditures?

Social and economic factors are even more important than health care as determinants of health. The health of a nation is directly related to the gradient in wealth between the well-off and the impoverished. Currently, deficit reduction is being achieved on the backs of the poor through cuts in social spending. The effect is to increase the economic disparity between haves and have-nots. This will inevitably have an adverse effect on Canadians' health, particularly on the health of the poor. The MRG therefore strongly opposes reduction in social expenditure.

## From where should the money come?

Previously, the MRG might have taken the position that we point out the adverse effects of reduced social and health care spending, and leave it for someone else to decide how to pay for it. The MRG Steering Committee believes that in the current climate this is no longer a tenable position.

One option is to stop worrying about the deficit, and get the money from government borrowing. As currently structured, the interest on the deficit represents an income transfer from Canadian taxpayers to finance capitalists, often from other countries. This is a strong reason to reduce the deficit. In addition, the political climate is such that arguing for maintaining deficit spending is likely a lost cause.

Therefore, ways must be found to increase government income.

There are a number of ways in which this could be done. Perhaps foremost is an increase in corporate taxes, particularly those on financial institutions. Financial institutions are reaping windfall profits ($4 billion for Canadian banks in 1994, and banks see increasing profitability in the current year). Many profitable companies paid no tax at all in 1994.▼

# Federal budget makes tragic choices for Canada's future

**By John Loxley**

The recent federal budget should please the money traders on Bay Street and on Wall Street, since it seems to have been prepared with their interests resoundingly in mind. I can't think of anyone else who should rejoice in it.

Finance Minister Paul Martin has sought to reach deficit reduction targets of three per cent of GDP by the end of 1996-97 essentially by cutting government services and laying off civil servants. His budget reduces program spending and transfers by $4.3 billion in 1995-96, and by $6.1 billion the following year, a combined cut of nine per cent. In 1997-98 it imposes further cuts of $11.9 billion, bringing the total to $25 billion in spending cuts over three years.

These draconian cuts are without precedent in peacetime Canada. Their impact on people will be dramatic. No less than 45,000 civil servants will lose their jobs, and there will be indirect job losses too. It has been estimated that for every $1 billion cut in government spending in Canada, between 20 and 30 thousand jobs are lost.

Some ways of raising taxes also cause job losses. This budget proposes to raise taxes by $3.7 billion over the next three years. In total, then, cuts and tax increases could reduce the number of potential jobs in the country by between 500,000 and 870,000 by the end of the three-year period covered in the budget. And this from a government elected on a platform of employment creation!

To make matters worse, the budget cuts Unemployment Insurance benefits and the infrastructure job creation program that was such a central feature of the "Red Book" platform on which this government campaigned for election. It lops 35 per cent off total spending by Human Resources Development Canada over the next three years.

Its forecasts accept that unemployment in Canada will remain in the 9.5 range for the foreseeable future. But even this ghastly figure looks optimistic. The budget forecasts a growth in employment of three per cent in the coming year. But last year, with much higher growth rates of GDP, employment grew by only 2.1 per cent. When you factor in such huge spending cuts, along with interest rates which are assumed to remain in the range of 7.5 to 8.5 per cent, it becomes clear that employment growth is likely to be severely constrained.

### The wrong tool

By putting the emphasis on spending cuts as the main way of shrinking the deficit, this budget is inevitably very close in its approach to that of the Reform Party. Indeed, in the area of social policy, it cuts even more over the next three years than the Reform Party has proposed: $4.5 vs. $3.5 billion. It cuts foreign aid by almost as much as Reform would (21 per cent vs. 27 per cent.)

Contrary to Reform proposals, however, the Martin budget increases funding for Aboriginal people, maintains equalization agreements and raises taxation, albeit marginally.

Furthermore, since the Liberal government does not try to eliminate the deficit altogether over three years, as Refomn proposes, the federal budget does not bite as deeply into transfers to individuals as Reform would.

Nonetheless, once the decision was made that spending cuts were to be the primary way of reducing the deficit, this government implicitly adopted Reform's approach. The remaining differences are ones of degree rather than of substance.

*Continued on next page*

---

*Continued from previous page*

Closing tax loopholes (particularly trust funds where the rich can secure their money tax-free), increasing income taxes on high earners, and instituting a wealth tax would be other sources of income. An additional strategy might include reducing interest rates which would decrease the interest burden on the government (if one excludes the interest on the federal debt, the federal government income already exceeds expenditures in the order of billions of dollars) and would increase employment (which would increase government revenue).

It is not up to the MRG to choose between these strategies, or to propose the relative emphasis that should be put on each. We can, however, point to these strategies as appropriate ways to finance social and health care expenditure which are crucial to maintaining a high-quality, equitable health care system, and maintaining Canadians health.▼

**Federal Budget...**
*Continued from Page Eleven*

## Whose voices were heard?

The government was certainly influenced more by Reform and the anti-tax lobby than it was by the social justice/labour movement and its spokespersons. The latter has always put a greater priority on creating jobs as the best way to deal with the deficit. The CHO!CES/CCPA Alternative Budget was based on this approach, reducing interest rates to stimulate jobs and income growth. It is out of the resulting additional income growth and reduced interest costs that the deficit would be cut without, therefore, cutting jobs below their present level. Indeed, the Alternative Budget would increase the total number of jobs in Canada.

Beyond that, the social justice/labour movement would put greater weight on taxing the wealthy, closing tax loopholes and ensuring that corporations pay their fair share of taxes. The Martin budget made a few token gestures at taxing banks, large corporations and wealthy Canadians; enough to annoy the anti-tax lobby, but far from enough to satisfy critics concerned with poverty and inequality, who had called for serious tax increases. There is no minimum corporate tax, no wealth tax, no increase in income tax, no surtax on high income earners That reticence, apparently, is in tune with the wishes of the bond market.

## For the poor: no new crumbs

Another area where the social justice/labour movement part company decisively with this government is over the issue of poverty. There is nothing in the Martin budget that addresses the needs of the poor in any new way. But there are moves which hold threats of losses soon to come for the poor. The proposed Canada Social Transfer, incorporating previous transfers to the provinces for health and post-secondary education and for social assistance, will come into effect in 1996-97 (after the referendum in Quebec.) The effect will be to cut these transfers by $4.5 billion by 1997-98.

Of course this will mean cuts in social assistance. It also signals a major backing away by the federal government from the whole area of social policy leadership. With a shrunken federal role, national standards in these areas will erode quickly. And even now they are pitifully inadequate in the area of social assistance.

The budget provides no tax breaks for the poor and no assistance to low income families with children. Social housing is cut, and there is no mention of expanding the child care system as was promised in the Red Book. It may well be that measures to expand child care and alleviate poverty will emerge later, as reforms to Human Resources Development programs are announced. But the budget of Axworthy's department has been so deeply cut that any future anti-poverty measures are likely to fall well short of election promises.

By all measures, the message of this budget is very clear: deficit reduction takes absolutely top priority over every other goal. It outclasses job creation, poverty alleviation and child care.

## A future of dependence?

Not a single mention is made in Paul Martin's budget of the need for Canada to reduce its dependence on foreign borrowing. By contrast, the Alternative Budget contained a number of proposals which would have this effect, and would allow Canada greater control over its economic and social destiny. For example, we could limit the extent to which RRSPs and pension finds (which receive tax breaks) are invested overseas. We could compel managers to invest a portion of these funds in Canadian government bonds. The Bank of Canada could be persuaded to buy more government debt. Commercial banks could be required to hold reserves in this form too.

None of this is radical. Much of it has been done before in Canada.

Above all, though, the Bank of Canada should be required to pursue policies that would reduce domestic interest rates. This would stimulate income and employment growth in Canada, and would reduce debt servicing costs for everyone. All of this would help reduce the deficit without having to resort to the cutting of social programs.

The real tragedy of the Martin budget is that this approach was rejected in favour of cut-and-slash strategies. Such strategies carry high human costs in terms of job and program cuts. They also undermine the government's ability to expand spending in areas of great social need.

An economic policy which creates jobs, rather than destroying them, is not only more humane; it is also a better and more lasting way to deal with the deficit. If combined with a much fairer taxation system, it would allow us to strengthen our social programs instead of dismantling them.▼

*John Loxley chairs the economics department of the University of Manitoba. He headed the national committee of volunteers which prepared the 1995 Alternative Federal Budget, a joint initiative of the Canadian Centre for Policy Alternatives and CHO!CES, a Winnipeg-based coalition for social justice. This article originally appeared in the March 19, 1995 issue of Catholic New Times.*

# New Zealand government rations life and death with attacks on health care

**By Felicity Coggan**

AUCKLAND, New Zealand - Retired meatpacker James McKeown won a round in the battle by working people to assert their right to health services when he was hooked up to a kidney dialysis machine here February 1.

Dialysis removes waste products from the bloodstream for people whose kidneys have ceased functioning. Without the treatment, McKeown was expected to live only three months.

Health authorities had initially denied the 76-year-old access to dialysis because of his age. But they were forced to back down in face of widespread public opposition after McKeown took his case to the media. His family initiated legal action under the Human Rights Act, which bans discrimination on the grounds of age.

Minister of Health Jenny Shipley insisted that McKeown was refused treatment for medical reasons. But doctors treating him explained that due to limited funding, they ration access to dialysis according to criteria drawn up by the government's Core Health Services Committee. Age, as well as "compliance" and "antisocial behavior," are among the criteria that have been prepared for 19 different areas of health and disability support services.

The Core Health Services Committee was originally set up by the National Party. government in 1991 to draw up a list of "core health services" that would remain publicly funded — and of those that would not. Last year the committee abandoned the task, saying it was too difficult, and instead turned its attention to developing criteria for restricting access to specific health services.

Auckland's Regional Health Authority explored the issue of rationing dialysis treatment at a meeting last September. Claiming increasing demand was straining the authority's budget, they put forward for discussion 13 grounds for refusing dialysis treatment — including blindness, mental handicap, major antisocial behavior, major psychiatric illness, and age over 75.

Restrictions on access to the more hightech forms of health care come in the context of continuing government cuts in public health services, ongoing moves to run medical services on a commercial basis, and the shifting of health costs onto individuals and families.

In the year to June 1993, government spending on health fell to 7.57 percent of gross domestic product, compared with 7.71 percent the year before. The same year government spending per capita dropped NZ$21, while private spending per capita rose NZ$47 (NZ$1.00=US$0.63).

Public hospital beds have dropped by 700 since 1993, when the government set up Crown Health Enterprises to run public hospitals as commercial enterprises.

The government's health reforms have included closing or downgrading public hospitals in smaller towns. This has met with resistance, most recently in Kaitaia, in the far north of the country, where 6,000 people — three quarters of the town's population — turned out February 9 to protest plans to downgrade the local hospital. "We're humans, not data," shouted one man on the march.

Public hospital waiting lists have grown 11.7 percent in the year to June 1994, and waiting times are longer. There are 77,000 people — more than 2 percent of the population — waiting for operations at public hospitals. Last March a senior surgeon at Dunedin Hospital resigned because of delays that he blamed on the health reforms, which he said could endanger patients' lives.

Meanwhile, last December, the chief executive of Northland Health, Dr. Bruce Gollop, weighed in with his solution to public hospital waiting lists. He explained that more people needing elective surgery, such as hip replacements, could be treated if staff did not have to spend so much time dealing with "avoidable" injuries from accidents and violence. He cited a breakdown in family values and parenting skills as the cause of much of the violence.▼

*Felicity Coggan is a member of the Meatworkers Union of Aotearoa in Auckland, New Zealand. This article originally appeared in The Militant.*

# Warning: This budget is dangerous to your health

*The Medical Reform Group issued the following statement on the federal budget on March 1.*

Paul Martin's budget further threatens our universal health care system, already under intense pressure. The federal cuts in transfer payments will weaken a system of delivering health care which is integral to what defines us as Canadians.

These cuts will have an adverse effect on the health of Canadians.

First, the government has slashed the size of the transfer payments to the provinces. By 1998, the federal government will have cut these transfer payments over the preceding three years by $8.5 billion.

The cuts in health care funding will squeeze public health care, fuel calls for an American-style two tiered system, and threaten our universal, equitable health care delivery system.

Coupled with the reduction, the government has collapsed transfer payments to the provinces in the areas of health, welfare, and post-secondary education into a single Canada Social Transfer, thus renouncing its responsibility for ensuring adequate health care across the country.

Second, we now know that health care is only one component of what keeps people healthy. The budget has also slashed the social safety net which provides services to those in need. Strong evidence suggests that the larger the gradient of income and wealth within a nation, the poorer the health of the people.

The federal Liberal budget will hurt the most vulnerable in our society, increasing the gap between the well-off and the poor, thus contributing to a deterioration in health.

The federal government has put together a budget to please financial markets, at the expense of attending to Canadians' human needs. The financial markets are pleased, but they ignore the human cost of the choice to avoid, for instance, serious increases in corporate taxes on financial institutions as a solution to the deficit.

The Medical Reform Group, a physicians' organization committed to the preservation of universal, equitable health care, find that the Liberal government, in its zeal to cut the budget, has compromised Canadian health care, and Canadians' health.▼

# Will the Liberal government betray Medicare?

*The MRG issued the following statement on the Liberal government's warnings of medicare cutbacks on March 6.*

Responding to questions about the social service funding cuts, Jean Chretien has said that Canadians will have to get used to a health-care system that provides basic care but no frills. Intergovernmental Affairs Minister Marcel Masse has suggested that the Canada Health Act could be revised and the federal government could make deals with provinces or groups of provinces. Paul Martin has suggested that provinces may respond to decreased transfer payments by charging user fees. These statements all suggest that the government is planning to change or abandon the principles embodied in the Canada Health Act.

The Canada Health Act protects the principle of universal health care by mandating the federal government to reduce transfer payments to provinces that allow user fees.

User fees penalize the sick and the poor, place barriers to access in the way of those who need health care most, and would ultimate destroy universal, high-quality care.

Health Minister Diane Marleau has said that she will enforce the Canada Health Act and penalize provinces that are allowing user fees. So far, Ms Marleau has penalized British Columbia, and given Alberta until October to end user fees or face federal penalties. Other provinces are also violating the Canada Health Act in ways that the federal Health Ministry has yet to address. Nevertheless, Ms Marleau's decision to enforce the Canada Health Act is wise, and vital to preserving national health care. Since the budget, Ms Marleau has issued a statement suggesting that she is still ready to enforce the Canada Health Act and penalize provinces which allow user fees.

The Liberal government's budget, in deeply slashing transfer payments to the provinces for health and social service spending, has undermined its moral authority to defend universal care. It now appears that, despite Ms Marleau's resolve, the federal govern-

# The Eugenics of Health Care in the U.S.

**By Johnny Townshend**

I am a healthy white male, age 34. I have never had a major illness or injury. But the present health care system still has no room for me.

I say I'm healthy, but it's been a year since I could afford to go to the dentist to have my teeth cleaned. It's been four years since I had an eye exam, and I get headaches when I read, so I expect I need a new lens prescription. My aunt has glaucoma, so I should probably be tested for that, but I can't afford it.

I have allergies every day of the year, inside or outside. I take two antihistamine pills every day and get by, but I wonder if I'm doing what's best for my body. I don't know, since I can't afford to see an allergist.

I have bursitis in my left shoulder, so I haven't been able to exercise in months. It hurts to sleep on my left side. It hurts to lift a plate with my left arm. It even hurts just to let my arm hang normally beside my body. It isn't an excruciating pain, yet it is enough to keep me from living as I normally would. But I can't afford an office visit and cortisone injection.

I've had tonsillitis a few times a year for several years. If I take antibiotics, it goes away, but often I have a mild case which just makes me extremely tired all the time. I suspect it's tonsillitis during those times, but I can't afford to see a doctor every time I think I have tonsillitis (or even when I know I do), so I just go on until it gets bad enough. I'd like to have my tonsils removed, but I can't afford it.

Then of course there's the dandruff. Over the years, I've tried every shampoo I can afford, but nothing helps much. A recent article suggested that dandruff is caused by an overproduction of yeast on the scalp and needs a prescription shampoo to be controlled, but if I could afford to go to a doctor, this certainly wouldn't be on the top of my list of problems, so I'll go on living with the dandruff, disgusting others and scratching my head till it bleeds, an irritating problem but not serious.

And I can't forget the canker sores inside my mouth, on the inside of my cheeks, on my gums, and under my tongue. I've had this strain of herpes since I was a child, and for as long as I can remember, I've had at least two or three sores a month. I hear that acyclovir can help, but who can afford a dollar a pill every day for a year? I just go on, sounding like a drunk when I get tongue ulcerations, and unable to eat for two or three days at a time. It's a good dieting practice, anyway, I tell myself.

All in all, I'm fairly healthy, with no major problems. I'm 5'10" and weigh 145 pounds. To all outward appearances, I look fit and sound. And relatively speaking, I suppose I am. But I just think that if I, who am healthier than most people, can't afford to take care of my small problems, how can we truly expect the average American to receive the care necessary to experience a decent life?

It seems to me that the prevailing attitude is that if I don't earn enough to purchase health, then I don't deserve it. I'm obviously not contributing enough to society. Therefore, my health is irrelevant because society won't miss me if I'm gone. The attitude is a kind of "survival of the fittest," suggesting that poor people can be sacrificed for the good of the rich. "Rich" is a relative term as well, and those of us who feel "poor" define it as being able to afford health insurance. These "wealthy" people would not dare actually suggest sterilization or extermination of the undesirables, but by denying adequate health care, they feel that "Nature" is simply following a "natural" course of eugenics.

That might be true except that health care itself is an unnatural, man-made product, the result of a social system. And when society deems that there is a significant segment which can be set adrift to fend for themselves while the powerful keep all the privileges for themselves, the action may be "human nature," but part of the

*Continued on next page*

**Will Liberals Betray...**

*Continued from Page Fourteen*

ment may be ready to abandon that responsibility altogether.

The Medical Reform Group, an organization of physicians dedicated to the preservation of universal, high-quality medical care, calls on the federal government to clarify its position on the Canada Health Act.

The clarification must come from the Prime Minister, who must state unequivocally that he will maintain universality by enforcing the Canada Health Act. The Liberals must reassert their determination to enact penalties to Alberta, and to other provinces which violate the Canada Health Act, for allowing extra billing.

Anything less will mean further jeopardizing the health care system that is crucial to the health of Canadians, and the cohesion of our society.▼

# 'Privatization not the answer'

Can the health system be the solution for the fiscal problems of governments? The current belief system would say that this is an absurd question, but that is not the contention of retired British physician Julian Tudor Hart. And Dr. Hart, who has written extensively and whose views are increasingly quoted in the major British medical journals, deserves to be listened to with respect.

If the objective of health care management and reform is the provision of the most cost effective approach for the benefit of the residents of the jurisdiction, the British National Health Service is obviously advantageous. It is the cheapest national system of a major industrialized system, at about 6% of GDP, far better than Canada's 9.5% and certainly the U.S.'s 14% (and growing).

Characteristic of the NHS is an essentially universal general practice registration and the defenders of the North American status quo find themselves in a difficult position if they try to claim that the higher costs are the result of increased patient demand. In the U.S. we see increasing attempts to control demand by the private bureaucratic controls of insurance companies, while in Canada governments are encouraged to explore delisting of procedures. Despite these attempts costs are not contained and, perhaps even worse, there are mismatches of care with both over-servicing and under-servicing of particular populations occurring at the same time.

Dr. Hart, who spent his working career as a GP in a small Welsh community, proclaims the fundamental advantages of the British approach of having a gatekeeping GP. That benefit arises to patient, physician and funder alike and in terms of clinical, career and fiscal satisfaction. The fact that no one has to be employed to collect money, to make sure that nobody gets care without paying for it, or to promote health care as a product to be sold not only makes a universalized system cheaper but it avoids the bureaucratic and managerial irritations that increasingly characterize the U.S.

In the field of public education, we expect a budget for school expenditure based on taxation revenue. Once it is understood that there is similar prepayment for non fee-for-service health care (and we could choose to restrict this to primary health care) many of the "problems" discussed in

**Eugenics...**

*Continued from Page Fifteen*

point of society is to compensate for the inhuman aspects of human nature.

We aren't ten wolves trying to feed off of one rabbit. There is enough to go around. But just as the wealthy feel they can never have enough wealth, they also fear they can never keep enough health stored away for them personally. Those who are in danger themselves of being weeded out if they can't keep paying their premiums have the irrational fear that it's better to sacrifice the poor rather than provide for their own future should they become one of those poor. "We can't take care of the whole world," the argument goes. Maybe not yet. But Americans can take care of Americans. It was Scrooge who declared that if the poor died it would be good and help "decrease the surplus population." Surely, that's not who we're using as a role model. Limiting the number of births seems a more humane way of dealing with overpopulation rather than letting people reproduce and then having them fight each other for resources such as health care.

It's not as if I'm just sitting around expecting people to clothe and feed me. I do have a job, but it doesn't pay enough for me to see a doctor. It's as if society only values my work enough to allow me to eat, but then says I have to take my chances from there.

I can't accept that it is scientifically sound or morally good either on a religious or societal level to endorse a policy where the ability to make money is considered a gene-marker for the superior race.

I could list personal accomplishments and talents to show that I do have worth even if I don't have money, but I don't believe I should have to prove that I deserve health. I am a human being, and as part of the human race, I feel it is my inalienable right to share in the medical knowledge and treatment that mankind has developed. Without it, I may die faster than others as I inevitably develop more serious problems in the future. But in the long run, if money is considered more important than humanity, the human race is already doomed to extinction. That is the eugenic policy of our present health care system.▼

publications such as the Fall 1994 *Canadian Healthcare Manager* disappear.

Experience in real life shows that it is not true that free availability of a service or product results in limitless demand — though this is the concept that textbook writing economists feel compelled to repeat. Doctors deserve to be well rewarded for effective care and there is ample scope for effectiveness as gatekeepers and coordinators of primary care. As a current example we see the growing demand (documented in the *Globe and Mail* of Dec. 5, 1994) for the formation and adequate funding of palliative care teams of physicians and nurses.

The article in the *Globe* insensitively refers to palliative care as medicine with no bells and whistles, presumably a journalistic attitude that real medicine always requires an oscilloscope. In fact such things as the precise pharmacological management of pain in terminal illness is exactly the sort of technical skill that trained physicians appreciate having the opportunity to apply.

Dr. Jackie Gardner Nix, the co-ordinator of a Scarborough, Ontario home-based palliative care program, makes a powerful case for physician leadership and management under government non fee-for-service funding. A team of participating community GPs, who otherwise devote themselves to regular practices, take responsibility for the care of terminally ill patients at home, for the patients' entire lives if possible. In comparison the advocates of the managerial and privatizing alternatives can only look foolish as they advocate expensive, less humane and less clinically involved solutions with such things as extra-billing and private insurance.

Why have North American family physicians not taken up the challenge of managerial leadership? Probably partly because they have been socialized to think that the small entrepreneur role is the only model and governments responded by establishing the fee-for-service payment system when medicare was introduced. In the earlier years of medicare the fundamental weaknesses of insured fee-for-service were not apparent, but now capped expenditures combined with an oversupply of metropolitan area physicians and undersupply in rural areas are demonstrating the impracticality of continuing along the same lines. The stale suggestions of privatization and delisting show the lack of solutions by failing to listen to practising physicians, who have a truer understanding of the needs and satisfactions of themselves and their patients.

Dr. Hart's major book on health reform is called *A New Kind of Doctor* (Merlin Press, London). Given the chance doctors can find a newer form of practice, allowing for greater involvement in management and applying epidemiological knowledge to the health of populations. Employers, workers and insurers, both public and private, will surprise themselves when they start looking closely at the benefits of a public system with the gentle management of healthcare professionals from the grass roots.

In a more recent book, *Feasible Socialism* (Socialist Health Association, London) Hart goes beyond the fiscal benefits to governments of a more efficient socialized health system (and acknowledges that it should not necessarily be less costly initially if underfunding of health resources is compensated for) to seeing health care as a model of new economic development of communities and countries. There is every reason to see this taking place in Canada with a move back to localized primary care reviving rural under-resourced areas. Job creation is the best way to avoiding tax increases.▼

**By Bob Frankford**

*Dr. Bob Frankford worked in family practice before being elected to the Ontario Legislature in 1990. This article first appeared in the Winter 1995 issue of Canadian Healthcare Manager.*

## 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.

# Draft policy on insured services

*Members of the Medical Reform Group Steering Committee have written a draft policy on the question of defining medically necessary insured services. MRG Members are invited to comment on this issue, and this draft position paper, by sending their thoughts to* ***Medical Reform****.*

As yet there is no clear definition of the insured health services that provincial governments are mandated to provide to the public. Although legislation stipulates that these services be comprehensive, the term comprehensive is open to interpretation. Thus, the various provincial health plans cover appreciably different services.

Recently, observers of the Canadian health care system have suggested that in the face of current budget restraints we cannot maintain the current level of public health care; that only "medically necessary" services should be covered. The implication is that resources will be saved by more precisely defining "medical necessity".

At first glance, this concept is attractive. Precise definition of insured services makes sense. Appropriate coverage would be determined by public values, and uniformity would be established among the provinces. Elimination of coverage for inappropriate services would reduce the burden on public spending. In theory, this would allow us to continue with universal coverage for the services that are really important.

There are, however, a number of problems with this approach. First, comprehensive coverage and medical necessity are entirely different concepts. Many health services, including dental care and many pharmaceuticals, are necessary for maintaining or restoring health, but are not considered "medically necessary" from the standpoint of coverage. Limiting exposure to environmental pollutants is necessary to maintain health, but is even further from usual concepts of medical necessity.

Second, even if one were to accept the limited scope of medical necessity, there are enormous practical difficulties in defining the correct range of insured benefits. While there are many services about which one can raise questions (tattoo removal, reversal of sterilization, for instance) one can always think of circumstances in which one would want those services covered. One can question the effectiveness of certain services (intensive psychotherapy, for example), but can also recognize situations in which they may be highly effective. The MRG has found, after extensive discussion of the range of appropriate insured services, that satisfactory resolution of this is not possible.

But more importantly, we must question the need for a precise definition of insured services. The Canadian health care system worked very well for 25 years without such a definition. Provincial governments have maintained acceptable coverage, and there have been few, if any, gross violations of the principle of comprehensiveness. Should such violations occur, the federal government can withhold funds from the offending provinces. So why the current debate?

The debate is a function of the budgetary pressures on governments. The cost-cutters see restricting the range of insured services as a way of trimming the system. But when one looks at what can be saved by deinsuring the controversial procedures, the amount is trivial. To really reduce public expenditure would require removing an unacceptably wide range of services. We believe that there is a deeper agenda underlying this debate; that the push for a definition of insured services is a manifestation of systematic attempts to undermine our universal public health care system.

With respect to definition of insured services, the system is not broken, and does not need to be fixed. The solution to the problem of cost pressures on the health care system include improving efficiency in health care, and revising our priorities on the mix of public and private resource allocation within our society. Rationing of resources is necessary. Canada's current rationing strategy of limiting resource availability (hospital beds, high technology equipment, the number of health care providers) and letting the public and health care providers work out the most efficient use of the resources available continues to be most appropriate.

The MRG's answer to the precise definition of necessary services is that we don't need such a definition. If pressed further, we believe that we should not consider defining medical necessity, but rather consider the components of comprehensive care required to maintain and enhance health. Under this framework, we would use the broadest definition of insurable services, including areas on the border of health care that nevertheless have an important impact on health. Our bottom line is that the debate about what is "medically necessary" distracts us from dealing with the real issues in health care delivery today.▼

# Ten steps to better health in Canada

*Across Canada, provincial governments are cutting services, closing beds and laying off workers. That's not health care reform. The Canadian Health Coalition, a national agency of churches, seniors' groups, community health groups and labour federations, including the OFL, says that real health reform takes the following 10 simple steps.*

## 1. CREATE A SUPPORTIVE ENVIRONMENT FOR GOOD HEALTH.

We must increase support for the preconditions of good health to really improve the health of the population. We need a job strategy to provide full employment, a strong social safety net, and other public policies that ensure shelter, education, food, peace, and a safe environment (including a safe work environment). Public policies that allow the gap between rich and poor to widen will lead to higher health costs.

## 2. PRESERVE AND STRENGTHEN THE CANADA HEALTH ACT.

Reinforce the five principles of the Act: universal coverage, accessibility, portability between provinces and territories, comprehensive coverage, and public non-profit administration. This coverage should apply to all types of health care. The federal government can enforce Canada-wide standards by threatening to withhold cash transfers to provinces that violate the Canada Health Act. The federal government must maintain sufficient cash transfers to the provinces for health care to sustain this power.

## 3. GOVERNING BODIES OF THE HEALTH CARE SYSTEM TO BE DEMOCRATIC, ACCOUNTABLE AND REPRESENTATIVE.

Health care is a vital part of Canadian public policy. Decisions on health care should not be left to private corporations or unaccountable boards. We need to expand the role of both the public at large and health care workers and involve them in ongoing evaluations of health care services. There should be genuine and ongoing public consultation on health care reform, as well as on the amount and allocation of health care spending. Elections to hospital and health care boards should be encouraged. Employer-sponsored "total quality" schemes that circumvent the elected representatives of workers must be replaced by bona fide moves to involve workers in workplace decision-making.

## 4. TRANSFORM EXISTING, UNACCOUNTABLE INSTITUTIONS TO PROVIDE A CONTINUUM OF CARE FROM LARGE ESTABLISHMENTS TO THE HOME.

This means providing good quality care with appropriate treatment and supports while providing choice of location to the user. Governments have used the rhetoric of moving to community care to downsize institutional care without actually expanding non-profit, accountable services in the community. Health care reforms should improve and increase services to seniors and the general public. Improving health care means doing a better job with what we have, not cutting for the sake of cutting.

## 5. WE SHOULD PROTECT OUR INVESTMENT IN THE SKILLS AND ABILITIES OF OUR HEALTH CARE WORKERS.

Cutting front-line workers means cutting quality of care. We have built up a tremendous resource in the skills and abilities of health care workers. This must be retained by

negotiating employment security agreements which enable displaced workers to access comparable jobs in the health care system. Allow health care workers to retain their existing rights by encouraging unionization in emerging health care organizations. With secure employment workers can participate more freely in the restructuring of the health care system.

## 6. ENSURE FAIR WAGES FOR ALL HEALTH CARE PROVIDERS.

The burden of providing health care is being shifted onto poorly paid workers in the community and unpaid family caregivers in the home, most of whom are women. Health care reform should not rob communities of"good jobs" and thereby contribute to the development of a low-wage economy. Wage parity with existing institutional jobs recognizes that fair wages and decent working conditions contribute to quality of care.

## 7. ELIMINATE PROFIT-MAKING FROM ILLNESS.

Public administration of medicare has saved Canadians billions and must be maintained and strengthened. Deinsuring health care services, creating profit-making health centres, and imposing user fees are examples of trends leading to a more expensive, two-tiered system where private in-

surance companies reap huge profits. There is no room for profit and inequity in health care.

### 8. REDUCE OVER-PRESCRIBING BY DOCTORS AND MAKE DRUCS MORE AFFORDABLE.

Transnational drug companies are adding millions to our health care costs by driving up prices. We need to repeal Bill C-91 (which extended drug patent protection) and enact genuine patent law reform that promotes lower drug prices. Controlling drug costs would free up millions for health care services.

### 9. STOP FEE-FOR-SERVICE PAYMENTS.

Most physicians, other health care providers, and private laboratories, are paid on the basis of the number and type of services they provide. This form of piece-work encourages overbooking, over-prescribing, over-treating and the concentration of physicians in urban areas at the expense of rural areas.

### 10. EXPAND THE ROLE OF NON-PHYSICIAN HEALTH PROVIDERS.

Nurses, midwives and others can handle many procedures within the full scope of their profession just as well as physicians, especially in areas that have been neglected by the medical profession, such as services for women or to other cultural communities. We must develop alternative health care models that expand the role of non-physicians health care providers. And more information should be made available to the public so they can make informed decisions and be aware of choices in treatment. Alternative approaches to health care which recognize the value of holistic health should be developed.▼

*From the September/October 1994 issue of Health Point of View, published by the Ontario Federation of Labour Research Project.*

# When health becomes a weapon

Twelve years of a brutal civil war, from 1980 to 1992, left the people of El Salvador, already familiar with the struggles of severe poverty, with acute health care needs and only pieces of a health care system, unable to provide more than marginal care for the majority. The Peace Accords signed in January 1992 have not put an end to either the increasing needs or the attacks on the health care system. Political and military factors continue to combine with economic ones to keep access to health coverage limited to a privileged few, while the majority suffer with few options for even minimal care.

One year ago, Frank Chalmers reported in *Health Matters* that the major causes of death in El Salvador were perinatal (11 per cent), intestinal infection (10 per cent) and murder or intentional injury (9.9 per cent). These statistics are telling both of the poverty and the widespread violence which have been prevalent. While these realities exist throughout the country, the situation is most acute where poverty and conflict have been most severe. In the countryside, where people are most poor and the conflict has been most intense, life expectancy is now 22 years less than the national average.[1]

In addition to the physical disease and injury resulting from the violence, Salvadorean society is suffering in ways that are not so easily quantified. Civilians as well as former combatants are experiencing the post-traumatic stress syndrome common after periods of violence and displacement, especially characteristic of civil war. During interviews conducted throughout central El Salvador, reports of massive mental health needs, stemming from the conflict, were constant from both national and international health care workers. The fact that there are no accurate statistics on this indicates the lack both of cultural recognition and of resources to measure and treat the problem.

Post-traumatic stress syndrome also has resulted in social fragmentation, evident at family, community and national levels. This is manifest in increased violence in both private and public spheres. Domestic violence, already a problem, appears to be soaring in the post-war era. This represents a significant public health threat, both mental and physical — primarily for women and children. One international mental health volunteer estimates that over 80 per cent of the women in the villages in which she recently worked in the western region suffer from beatings and other abuse from their partners.

Common street crimes (muggings, physical attacks, etc.) are increasing in number and in violence. Aggravated by economic hardship and greater availability of weapons, in-

*Continued on next page*

creased street crime is both cause and effect of the general insecurity of the post-war transition.

Youth gangs, another symptom of the current psycho-social conditions, are growing. This complex phenomenon was imported from the U.S. by children who fled the violence in El Salvador only to become involved in another kind of warfare in their often hostile host country and who now have returned as young adults.[2]

Both the family and the Church, traditionally the most available (if imperfect) sources of support, have been sharply divided by the violence and displacement consequent on the civil war. So not only are common social problems such as street and domestic violence increasingly prevalent and new ones such as gang violence taking root, but the social institutions traditionally in place to deal with such upheaval have themselves been ruptured. For most people this means greater vulnerability in physical, mental and spiritual terms, which contributes to the critical state of public health.

The current crisis in health care is not only an unfortunate symptom of underdevelopment or an accidental casualty of the war. Health care was an explicit target of the military during the war; health workers in rural areas were persecuted routinely and systematically. This was part of a larger 'scorched earth' policy in which the military attacked not only guerrillas or their specific sympathisers, but rather whole villages and regions. Intentionally targeting those who provided health care to rural villages was one of the more sophisticated and efficient ways of attacking entire populations.[3]

During this same period, the Farabundo Marti National Liberation (FMLN) guerrillas established an impressive network of health promoters who reached many in the rural areas. In many cases these were young people with little formal schooling, who learned their skills mostly by experience — from basic diagnoses of common village illnesses to field surgeries, often under extremely trying conditions. In addition to whatever genuine interest the FMLN may have had in the well-being of the poor majority, they also benefited as an organisation from the health promoters' work. Rural health care was not only essential in order for their combatants to have access to treatment, but an effective way to win and maintain the loyalty of civilians.[4]

Health care in El Salvador has been a military weapon. In addition to diminishing its accessibility, this has distorted its very nature. In post-war El Salvador the lives of the people, especially the rural poor, remain pawns in a game of power as health care continues to be a weapon, now in the political rather than the military arena.

One of the most prominent examples is the fate of rural health promoters and the populations they have served. Many of these health workers were previously funded by international organisations, often through factions of the FMLN or other local non-governmental organisations (NGOs). Since the official end of the war in January 1992, international resources and attention have been diverted elsewhere to more apparently urgent needs.

Not only are there fewer resources on the left in general, but the FMLN has been directing those resources elsewhere. The transition from a military force of five factions to an opposition political coalition has unfortunately resulted in budget cuts in health while funds are concentrated in the establishment and maintenance of formal political organisations. Additionally, the left is being damaged by its own lack of unity. Recently defeated by the far-right ruling party ARENA (National Republican Alliance) in April's contested presidential elections, disorganisation and infighting continue to plague the left, exacerbating the tendency to spend on bureaucratic demands, leaving fewer resources for health care and making co-operation in health work difficult if not impossible.

Meanwhile, dubiously-elected President Armando Calderon Sol has promised to expand the neo-liberal project begun by his predecessor. Central to this plan is reduction of social spending and privatisation of many basic services. The people of El Salvador cannot depend on the government to provide an increase in resources for health care. Strikes by workers in different sectors of the state health care system have been frequent in the past two years, most recently to protest the privatisation of the state social security institute.[5]

While there have been some isolated government attempts to train, certify and fund a few rural health promoters, thousands of those who were trained and funded during the war are having to leave health care work in order to be able to earn a living. Most of these will not qualify for either training or certification by the government, and therefore cannot be state-employed, nor is there funding for more than a tiny minority available through NGOs. As the new government continues to cut funding for the state system, the network of grassroots health workers dissolves,

*Continued on Page 22*

**When Health Becomes...**
*Continued from Page Twenty-One*

leaving millions with no access to even minimal regular care.

But health care in the post-war era is suffering not only neglect within broad economic policy. There are many who do not want good health care for the majority, especially in the rural areas where the tenure of the majority of land that was to be distributed under the Peace Accords has yet to be resolved. Providing decent health care in areas where property rights are still contested is seen as tantamount to legitimising the claims of the people currently living there, in many cases squatters who established communities on land abandoned by large land owners during the war. Given the potential for large profits on such lands in the ever more neo-liberal economy there are many with wealth and power who continue to block any real investment in health care in the countryside .

Just as health care was previously denied to the majority for military motives, today health care is denied for political and economic motives. During the war the international community made the difference by supporting the work of health promoters in the countryside.

Given the current political and economic interests opposing expanded government investment in health care and the crisis of unity in the left, international involvement is as crucial as ever — this time not simply to respond to immediate, war-induced crises but to support the construction of a sustainable, just health care system for the future.▼

**References**

1. Chalmers F. *Health Matters in Central America*, Autumn 1993.

2. O'Connor M. A new US import in El Salvador: street gangs. *New York Times (International)*. 3 July 1994.

3. Lundgren R, Lang R. 'There is no sea, only fish': effects of U.S. policy on the health care of the displaced in El Salvador. Soc Sci Med 1989; 28(7).

4. Spickard J, Jameson M. Health care in rural El Salvador. In: *Global perspectives on health care*. Prentice-Hall: publication due 1994.

5. Resource Center of the Americas. *Centroamerica — the month in review*, 1994: 9(8).

*I am grateful for the assistance and support of the staff of the Center for Global Education and the International Medical Relief Fund in Salinas, California.*

**Melissa Jameson**
*Melissa Jameson is a volunteer worker at the Center for Global Education in Mexico.*

*This article originally appeared in the Fall 1994 issue of* ***Health Matters****. Subscriptions are 24/year from Health Matters, Freepost SF 10539, P.O. Box 459, Sheffield S11 8TE, United Kingdom.*

# Comments from the Membership

*The membership renewal notices for the current year invited members to state their views on what issues the MRG should be concentrating on, and to make any other comments on the activities of the MRG. A selection of comments from the membership forms follows:*

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

- Cutbacks in federal transfer payments such that control over health care will be eventually provincialized and thus not universally accessible and equitable.
- Vocal profile.
- Methods of physician payment (capitation). I also think the MRG should take a (pro) position on physician assisted suicide.
- 1. Move towards salaries rather than fee for service, especially for those MDs working exclusively in hospitals, i.e. using publicly funded institutions; 2. Work to preserve universal coverage. 3. Publicize the fact that federal transfer payments to provinces will be zero by early 2000s.
- De-listing OHIP services. Federal contribution to provinces to ensure uniformity in medicare across provinces.
- Widespread careless attitude to good medicines.
- Effect of current government politics on funding of young medical researchers.
- Enshrine five principles of medicare in provincial law.
- 1. Female genital mutilation. 2. Midwives as part of the health care team. 3. Unnecessary hysterectomies.
- User fees/privatisation/hospital restructuring.

- Pharmaceutical companies in CME; rational prescribing; "medically necessary" treatment; NAFTA.
- *Responsible* health care reform — health care budgets — nurse practitioners, midwives.
- Health care services funding, priorities, etc. Should certain procedures which cannot be funded by state be available on private funding basis? Role of public health in this debate?
- Primary care. Role of nurse practitioners.
- Issues related to medical education.
- Allocation of physician/medical resources and reform of physician remuneration.
- Powers and temptations of the pharmaceutical companies; doctors resist their many gifts. Make healing drugs available to all at moderate prices. Challenge the lobbies in Ottawa.
- Accessible humane health care.
- I support the direction of past and current policies but would in addition like to see the MRG be more visible around abortion. In particular access remains a major issue for many Canadian women. I would also have wished the MRG would have been more visible after the recent shooting in Vancouver.

# CFPOs' attempt 'to use patients' in political battle draws fire

BY NANCY DEUTSCH

TORONTO — Patient care and politics don't mix. That's the message some doctors are sending to the Ontario chapter of the College of Family Physicians.

Members of the Medical Reform Group (MRG) are protesting a recent package sent by the college to doctors suggesting they solicit patient support to combat government moves to expand the role of nurse practitioners.

In the letter sent to family doctors, CFPO president Dr. Marlene Spruyt says that the college is concerned with the cost to patients and the impact on quality of care if nurse practitioners are allowed to practice independently rather than as part of a multidisciplinary team.

The Ontario Ministry of Health, the letter said, has suggested that nurse practitioners could become autonomous care providers.

"We appreciate that it is not an easy issue to discuss in the context of an office visit," the letter reads. "At the same time ... we believe that the patient/physician relationship is the key to "mobilizing" the public on this issue ... We also encourage you to raise these concerns with your MPPs ... flood the media with information ... encourage your patients to do the same."

The letter has made some physicians angry.

"It's wrong for the physician to use the patient-physician relationship for political purposes," said Dr. Mimi Divinsky, an MRG steering committee member.

About 200 doctors and medical students are members of the MRG, a group that claims to be socially-concerned, and speaks out when they feel a medical organization is not acting responsibly.

Dr. Divinsky said when she received the letter and a bunch of brochures to place in the waiting room for patients, she was "surprised and disillusioned. I've always admired the College of Family Physicians [but] they've made a mistake."

An MRG press release states that: "the Medical Reform group condemns Dr. Spruyt's attempt to use patients in the college's political battle with the government."

"We want to draw media attention to it and hope FPs will think again about using patients in this way," Dr. Divinsky said.

**Continued on page 2**

## Medical Reform Group blasts college of FPs

**Continued from page 1**

To use the little time physicians have with their patients for political purposes is wrong, she added.

"We feel very strongly this is a gross misuse of the patient-physician relationship."

Doctors also have a great deal of power with patients, and "we have to be very careful about using that."

Elderly patients are particularly unwilling to challenge their physician, she said.

Cheryl Katz, executive director of CFPO told ***Family Practice*** the letter was not meant to suggest physicians lobby patients, but that "in the event that this issue comes up, it's more than appropriate to provide information."

However, the letter sent to doctors does not mention who should bring up the topic.

"It's very appropriate to discuss health-care issues and primary care," Katz added. "That's what FPs are trained to talk about."

**Dr. Spruyt**

The brochures sent with the letter were not meant to be a lobbying ploy, they simply outline the family physicians's role in case members of the public are unclear, said Katz.

While CFPO sent out the brochures with its letter, that decision was made to save mailing costs, not because one was meant to complement the other.

Katz added that the MRG did not need to air its concerns through the media, but could have contacted the college directly.

The new role the ministry is outlining for nurses is setting up "a competitive health-care system that pits one group against another," said Katz.

The college's main concern is that the ministry made its decision to give nurse practitioners more autonomy without going through the Health Professions Regulatory Advisory Council, said Katz.

Furthermore, the CFPO estimates it will cost $60 million to train and employ 75 nurse practitioners per year for five years. Salary increases and support services will add even more to the cost.

"If there's no real demand for it, it's a real waste of taxpayers' money," Katz said, since no recent study shows the need for this initiative now.

Peggy Snyder, chair of the Nurse Practitioners Association of Ontario said nurse practitioners will not be in competition with physicians.

"There is no intent for nurses to hang up their shingle and set up practice in competition with family practitioners," she told ***Family Practice.***

FEBRUARY 6, 1995

# Medicare under the knife

## With Ottawa looking for ways to slash spending Canada's health care system may receive some emergency treatment

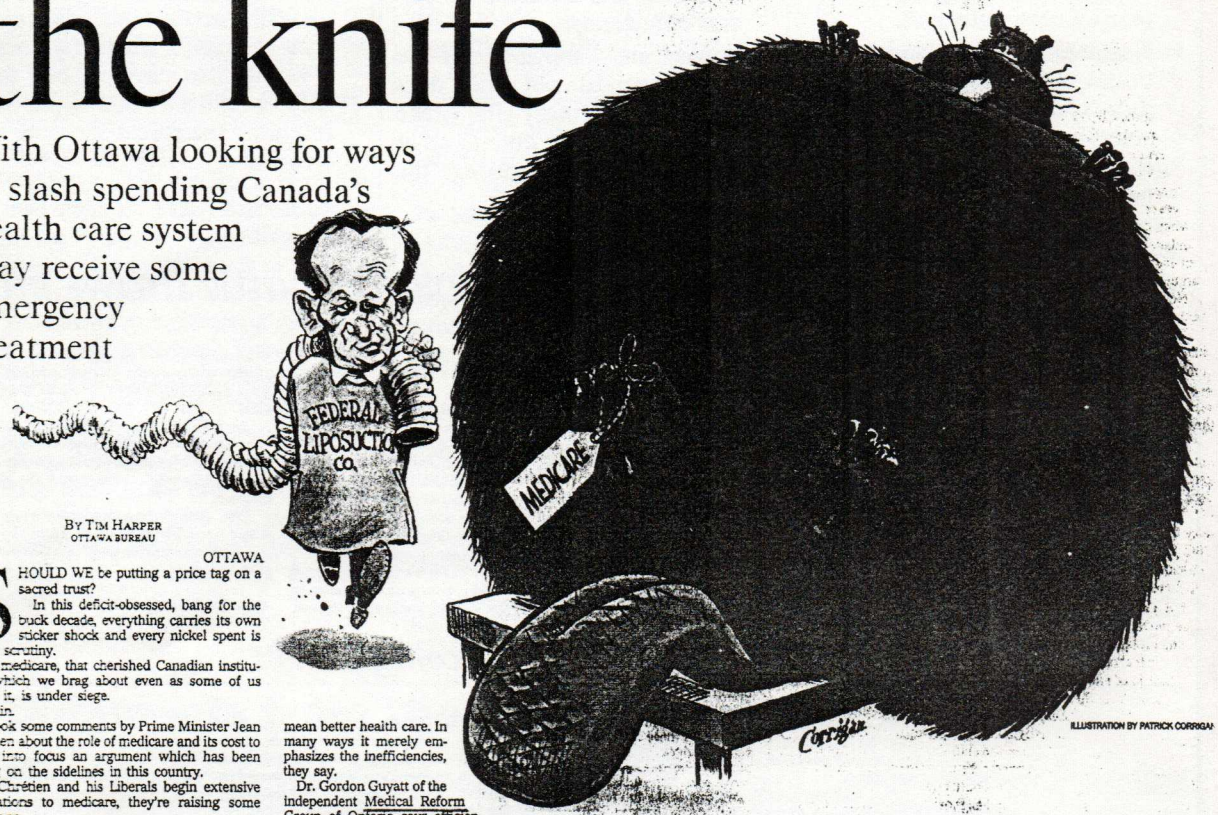


ILLUSTRATION BY PATRICK CORRIGAN

By Tim Harper
Ottawa Bureau

OTTAWA

SHOULD WE be putting a price tag on a sacred trust?

In this deficit-obsessed, bang for the buck decade, everything carries its own sticker shock and every nickel spent is under scrutiny.

So, medicare, that cherished Canadian institution which we brag about even as some of us abuse it, is under siege.

Again.

It took some comments by Prime Minister Jean Chrétien about the role of medicare and its cost to bring into focus an argument which has been raging on the sidelines in this country.

As Chrétien and his Liberals begin extensive renovations to medicare, they're raising some questions:

- Is our health-care system efficient?
- Can medicare be saved even when that system takes a major whack from the budgetary knife?
- Have we become, as consumers, spoiled, using emergency wards for ingrown toenails and hauling our children off to the hospital at the first sign of sniffles?

Increasingly, a chorus of critics, economists and government officials are answering "Yes!" to all those questions.

Their message is that Canadians should get used to a system in which hospital stays are shorter, after-care programs and clinics are more in tune with community needs, the brakes are applied to the over-prescribing of drugs and more emphasis is placed on remaining healthy, not being treated when ill.

"There is evidence which shows we threw billions more dollars at health care in the 1980s," says Judith Maxwell, president of the Canadian Policy Research Network and author of a three-year study on health-care savings released in January.

"All we were doing was taking more pills, making more visits to the doctor and taking advantage of more acute care in hospitals.

"There's no evidence to suggest people were any sicker in the 1980s. We can't say we got any extra value for that extra money."

Therein lies the problem with medicare today, many critics say.

Spending more money on health care doesn't mean better health care. In many ways it merely emphasizes the inefficiencies, they say.

Dr. Gordon Guyatt of the independent Medical Reform Group of Ontario says efficiencies can be achieved by beginning at the primary doctor's level, and by cutting back on useless laboratory work and "investigative" work done by doctors.

But instead of blaming the consumer, Guyatt says, much of the blame for a flabby system lies with his brothers and sisters of the medical profession.

"If the elderly are taking too many pills, well, they're not prescribing them themselves," Guyatt says. "Half the cost to our health-care system is hospital costs.

"People aren't checking themselves into these hospitals.

"And I don't know about your leisure time, but I don't really know of anyone who thinks it's a fun trip to run down to the emergency room and sit there for a few hours waiting to see a doctor.

"Logic dictates that type of behavior is not an appreciable drain on the system."

Officials in Chrétien's office say the Prime Minister is merely talking about bringing health care expenditures in line with shrinking government spending in other areas.

"But we know medicare is a delicate subject and we have to explain ourselves very clearly," one official said.

Canada spends 10 per cent of its Gross Domestic Product on health care.

Citing the European experience, Chrétien has suggested he would like to get that figure down to 8 or 9 per cent, which would bring it in line with countries like France and Germany.

"I'm of the view that we have to reduce it under 9, to be in the same range as those who have full medicare in Europe," he said. "They manage to do it within around 8 to 9 per cent of GDP, so we will do it."

What isn't clear is how he would do that and maintain the principles of universal medicare.

France and Germany, for example, charge user fees for some services and charge people for part of their insurance if they can afford it. The Liberals have rejected user fees.

If Chrétien does slice health spending from 10 per cent of GDP to 8 per cent, he'd be cutting anywhere from $12 billion to $18 billion from the system, depending on how strong the country's economic performance was.

Chrétien's statement this week follows last week's, when he made it clear Canadians should get used to a no-frills medical system that provides basic care, but not ambulance rides.

"That can't help but have ramifications," said Judith Oulton, executive-director of the Canadian Nurses Association.

"At the same time, he's cutting other social spending. When you cut back in other social areas, you put more burden on the health-care system."

In 1977, Ottawa was funding 50 per cent of health-care spending in the country. Then the slide began and it would continue under former prime minister Brian Mulroney.

In 1980-81, federal spending on health care wa $6.8 billion. Three years later, in those free spending days, it had jumped to $9.5 billion.

When the Conservatives came to power i 1984, Ottawa was paying 31 per cent of the na tional health-care bill. They slowed the rate o spending dramatically. From 1989 to 1992, Otta wa's share of the health-care tab inched up, fron $14.1 billion to $14.6 billion.

By 1990, Mulroney had frozen health-car transfers to the provinces until the end of 199 sending them scrambling to maintain service That meant that, by 1991, the federal share of th tab had slipped to 24 per cent.

By 1994, Ottawa was providing about $16 bil lion in health-care funding to the provinces.

Then came last month's Liberal budget, whe Martin announced the federal government woul transfer $26.9 billion to the provinces in 1996-9 for education, welfare *and* health. That will d cline to $25.1 billion the following year.

While in opposition, Chrétien was adamant th national health-care standards would not declin under a Liberal government. There would neve be user fees, he vowed.

"The Liberals will not play around with med care," he said as opposition leader.

Yet, this past week, Chrétien, Martin ar Health Minister Diane Marleau have all tried assuage a growing number of critics by insistir

(B7 Please see Bloated, E