MEDICAL REFORM

Newsletter of the Medical Reform Group

Medical Reform Group, P.O. Box 40074, 280 Viewmount Ave, Toronto, Ontario M6B 4K4

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Transitions

In August of this year, the MRG bade a fond farewell to Ulli Diemer. Ulli, in his role as Administrative Co-ordinator, had the many and varied responsibilities of keeping the MRG organized and functioning. Many of our accomplishments over the past 12 years would not have been possible without his administrative skills.

Ulli has moved on to become General Manager of "Sources", an independent general reference publication specializing in the provision of human contacts. In Ulli's words: "I am taking on some new commitments, a key component of which will be a project I'm very excited about, to make the ideas and analyses of the left more widely available through a variety of electronic and print formats." We wish him continued success.

Janet Maher was hired in August as our new Admin-

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THE COMMON SENSE REVOLUTION

Ian Scott

It appears that our government no longer feels nor cares for a significant portion of the people they were elected to govern. It is indeed a frightening time as we see a government filled with "passionate intensity" to carry out a mandate that will have a significant negative impact on the health and well-being of Ontarians of this generation and generations to come.

INSIDE

What does the Harris government have in store for those who are marginalized and the many more who will be newly marginalized in our society as a result of the "Revolution?" If we are to understand the impact of the "Common Sense Revolution" on our patients, we must consider health in its broadest sense: health as well-being.

The "plan" calls for annual cuts of $6 billion. This represents a cut of 20% of non-priority government spending in 3 years. Now, the premier has announced that spending will be cut $9 billion annually, 50 % more than was promised during the election. To date, there have been $5.53 billion in cuts put on the table. The government's commitment to these cuts are, in their own words, "carved in stone."

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Medical Reform

Medical Reform is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at $25 per 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 40074, 280 Viewmount Avenue, Toronto M6B 4K4. Phone: (416) 588-9167; Fax (416) 782-9054; e-mail: jemaher@web.apc.org

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

Editorial Board: Mimi Divinsky, Ian Scott, Lena Fung, Gord Guyatt, Janet Maher

Layout: Vera Ndaba

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 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 contribution of all health care workers is recognized. Both the public and health care workers should have a direct say in resource allocation and in determining the setting in which health care is provided.

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istrator. In addition to her data management skills, Janet has been a long-time activist on women's, social policy and social planning issues. She has not only written briefs for many voluntary sector advocacy groups over the years on federal-provincial and municipal legislation, funding arrangements, and taxation relating to education, health, and social assistance, and the like, but has worked with a broad range of membership-based groups to organize educational, media and lobby campaigns on Medicare, child care, the constitution, pay and employment equity, and community economic development, to name just a few.

Our new administrator has a wealth of experience with volunteer boards, having served on several herself, including the Canadian Health Coalition, and the National Action Committee on the Status of Women. She also participated on the Women and Tax working group of the Ontario Fair Tax Commission. Janet continues to be active as chairperson of her local social planning council.

Janet's fax and e-mail networks are without equal in the progressive community, and we look forward to working with a very able successor to Ulli Diemer◆

The Determinants of Health: How can we pay for them?

Summary of the MRG Spring General Meeting

by Ian Scott

John Frank, MRG member, made a presentation to the May Semi Annual General Meeting on May 3, 1995 on the Broader Determinants of Health. Following John's presentation, we had a lively discussion on funding in the context of austerity. Members reached consensus quickly in some areas, but not in others.

Six points arose from out discussion. These are, in no order of priority:

1. We are a physicians' group and therefore we have significant credibility when speaking to health and health care issues. If we are to advise the public on "where the money

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The Common Sense..
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Cuts announced to date include:

1. The elimination of all premier's councils (including the Premier's Health Council).

2. The possible closing of 38 hospitals across Ontario as early as April, 1996.

3. The expected reduction of funds for hospitals by 10% this fall.

4. The cutting of funds to public health units and the reduction of the number of district health councils.

5. Cuts to the $1.3 billion Ontario Drug Benefit Plan by the income testing of recipients.

6. The reduction of WCB benefits from 90% net average earnings to 85% with limits on entitlements.

7. The reduction in funding for the Advocacy Commission pending the repeal of the Advocacy Act.

8. The gutting of welfare payments as of October 1st. Single employable adults, who now receive $663 a month, will receive $520 a month. Sole support parents with one child, who now receive $1221 a month will, receive $957 a month (a 21.6% reduction).

9. The repeal of the Employment Standards Act, part of which protects workers owed wages by companies that go out of business.

10. The halving of the budget of the Ministry of Labour. This proposal would entail cutting 20% of its safety inspectors and closing most of its research laboratories. The leaked proposal notes that, "The ministry would only respond when the workplace parties have exhausted their means to control a hazard or solve a problem or when a critical or fatal accident occurs."

11. The repeal of Bill 40. This bill bans the use of outside workers during strikes, facilitates the hiring of women and minorities, and makes it easier for workers to organize their work places.

12. The capping of pay equity.

13. The possible elimination of funding for junior kindergarten.

14. The elimination of 15% of the government work-force.

15. A decrease in municipal transfers by as much as 20%.

What impact will this have on our patients?

1. More people will be requiring social assistance. After the cut of social assistance, 21.6% will not be adequate and many will be evicted from their current housing without being able to find subsequent housing.

2. Women will continue to be paid less for work of equal value.

3. Workers injured on the job will not be compensated fairly, nor in a timely manner.

4. Employers will be able to break unions more easily in a time when working people are under threat from the government's other policies.

5. Unemployment will increase.

6. Significant pressures will be put on health care and calls for a two-tier system will increase. Means testing seniors for ODB signals the beginning of calls for a two-tier health care system.

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How will Harris' cuts affect the health of Ontarians?

1. Unemployment: For every 2,000 Canadians who are unemployed, 2 will die as a direct result of being unemployed. Physical and psychological morbidity of the unemployed will increase. The direct and indirect costs (production, earnings, taxes, UIC payments, etc.) of 10% unemployment to Ontarians is approximately $33 billion per year.

2. Fear of job loss: Fear of job loss increases the death rate in populations at risk for cardiovascular disease by 1/1000 for 6 years of follow-up. Additionally, psychological morbidity and visits to the physician increase when workers are threatened with job loss.

3. Poverty: Labourers have more than double the mortality rate from heart disease of managers and professionals. Children born into poor neighbourhoods are twice as likely to die as children born into rich neighbourhoods. Even more striking is the relationship between poverty and life expectancy. Boys and girls born into the poorest fifth of Canadian society have a life expectancy of 5.6 and 1.8 years less, respectively, than boys and girls born into the richest fifth of Canadian society. Eliminating this difference would have the same effect on the health of Canadians as would eliminating all deaths from strokes and heart disease. Presently, 18% of all of Canada's children live in poverty.

Government cutbacks will clearly lead to job loss and job insecurity. Many more will be impacted by government cuts in social services, reductions in equity legislation, and reductions in services to support the vulnerable. Who then does the "Common Sense Revolution" serve? Tax cuts promised by the "Common Sense Revolution" will disproportionately reward the elite. A couple with a combined income of $30,000 will save about $12 a week or $600 a year in taxes. A couple earning $50,000 will save about $18 a week, and a couple earning $75,000 will save $34 a week. An individual earning $75,000 will save $61 a week or a little over $3,000. Clearly we see whose agenda is being served by this government.◆

Values Gap

Ekos Research Associates found, in a year-long study of some 3,500 Canadians a massive gap between what the elite and common Canadians think government should do. In a list of 22 values for the federal government. Ordinary people think that the government should uphold the values they cherish and act to put those values in practice. The elite focused almost entirely on deficit reduction.

For the elites, the number one value was competitiveness, followed by integrity, minimal government, thriftiness, excellence, self reliance, prosperity, a healthy population (number 8), and a clean environment

For the public, freedom was number one followed by a clean environment, a healthy population, integrity, individual rights, security and safety, equality for all regions, self-reliance, respect for authority, and collective rights.

The elite's favourite, competitiveness, ranked 20th for the public which put the elite's number 3 choice, minimal government dead last.◆

Ontario Medical Association's advocacy of Privatization betrays Ontario

The MRG issued the following media release on June 12

The Ontario Medical Association, in a report endorsed by the OMA Council, has introduced another threat to universal health care. Those who can pay will receive better care. The OMA would open the door to private insurance for publicly insured services, and would introduce user fees.

The OMA policies would end the health care system as we have known it. This OMA policy stands in explicit contradiction to the Canada Health Act, the federal legislation that enshrines the principle of universal health care. Instead, it represents a dramatic suggestion that we "Americanize" our system. The results of this move would be a health care system in which financial burdens could accompany the suffering of serious illness; the well-off would receive better care than the poor. User fees will penalize the sick and the poor and place financial barriers to access in the way of those who most need health care. Research on user fees has shown that costs would rise, and efficiency would fall. The only beneficiaries would be certain physicians, whose income would increase.

Unfortunately, this appears to be the policy's prime motivation. The OMA's position contradicts not only federal legislation, but both the interests and the overwhelming opinion of Ontario citizens. Not all physicians agree with the OMA's new policy. The Medical Reform Group, an organization of physicians dedicated to the preservation of universal, high-quality medical care, sees the OMA position as a betrayal of public trust. The OMA's willingness to take this position highlights the severe jeopardy in which we find the principles of universal health care. Only strong opposition to further health care cuts, and to the introduction of user fees, will save Canada's most valued social institution.

The OMA's policy paper is not about reform. It is about the protection and supplementation of certain physicians' incomes at the expense of the Canada Health Act, and the health of Ontario citizens. The Medical Reform Group believes that the OMA has the diagnosis, and the prescription, all wrong. ◆

Strategic Planning for the Medical Reform Group

The fall semi-annual meeting takes on a new format

Much of what we have taken for granted for most of our adult lives in this country is seriously in jeopardy, with a federal government which appears to be carrying on the Tory agenda of their predecessors. In June this year, Ontario elected a slate of radical Tories, who are not only eager to pass on the federal cuts, but add to them—through a range of cuts in payments to lower levels of government, to transfer agencies and to individuals.

While Medicare has been invoked by all as a sacred trust, we are daily witnessing shifts and erosions at every level—medical and general health research, institutional and community programs, as well as in the allied social programs—notably housing and income support—which gave us at least some chance at maintaining or enhancing the health status of Canadians.

Your steering committee has worked hard over the past year to give profile to con-

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structive approaches to maintaining and enhancing access to a publicly-administered high quality comprehensive and universal health care system. To increase our effectiveness at this critical time for Medicare in Canada, though we need to review our goals, strategies and resources.

Determinants of Health...

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should come from" we must use credible individuals or well referenced literature as our sources. If we speak as economists we may lose credibility which would harm us when we speak on health and health care issues.

2. An alternative strategy to advising on "where the money should come from" would be to advocate for more efficiency in government or making broad statements such as "the Health Care system is more important to Canadians than the Military system".

3. If we agree that the envelope for health care need be no bigger (and it is not clear we have agreed on this as there was much discussion on this point), we should advocate for more efficiency in the health care system. As a physicians' group, we can recommend areas where expenditures can be cut. Such recommendations are problematic. If we recommend cuts we must ensure that these funds remain within the health and social service systems and not moved into such things as prisons or the military.

4. We should continue our stand on no user fees, physician remuneration by capitation for primary care and salary for speciality care, and no cuts to social programmes.

5. As a progressive physicians' group, we are well aware of the importance of the broad social determinants of health in the construction of illness and health in our society. We must understand that many others in our society are not as acutely aware of this important relationship between social determinants and health. We should continue to use our influence as a group of physicians to publicise the importance of the broad determinants of health.

6. We should be more proactive in seeking solutions with other progressive move-

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Come to our Strategic Planning Retreat
Saturday, November 18th, 1995
9.30 am to 5.00 pm
Japanese Canadian Cultural Centre
123 Wynford Drive Don Mills

Draft Agenda includes

9.30 - 11.00 am
Environmental Scan: What's going on?

11.15 - 12.30 pm
Goals: Where does MRG fit in the scheme of things?

12.30 - 1.30 pm
Lunch

1.30 - 2.45 pm
Resource Evaluation:
a] external: Who can/should we work with?

3.00 - 4.15 pm
Resource Evaluation:
b] internal: How do we organize ourselves to do the priority work effectively

4.15 - 5.00 pm
A work plan and calendar for the 1995-96 year

RSVP to Janet Maher by November 8, or if you have items to add to the agenda.◆

Ontario Should Consider B.C.'s Cost-saving Drug Plan

The MRG issued the following media release on July 5

The multinational pharmaceutical industry, defending its commercial interests, is attacking a British Columbia plan to save taxpayers money on prescription drugs. When there is more than one therapeutically equivalent drug available, the British Columbia plan, as reported in the Globe and Mail, July 5, 1995, would pay only for the lowest-priced of these therapeutically equivalent drugs.

Under the B.C. proposal, called reference-based pricing, if a doctor prescribed a more expensive drug, there would be two options. First, the doctor could justify the need for the more expensive drug, in which case the government would reimburse the cost. If the doctor could not justify her drug choice, the government would pay only for the cheaper effective alternative. Similar plans have been used in other constituencies, including Germany.

Many new expensive drugs offer no advantages over existing, less expensive alternatives. The pharmaceutical industry, through sophisticated advertising, is often successful in persuading physicians to prescribe such drugs. The result is needless cost to patients, with no benefit.

Pharmaceutical industry advertising is often misleading, and always slanted in favour of the industry. Doctors often do not have the time nor the expertise to distinguish between accurate and misleading claims. Industry efforts contribute toward physicians' suboptimal drug prescribing which has been documented in many studies.

As reported in the Globe and Mail, the Pharmaceutical Manufacturers' Association of Canada, representing the multinational pharmaceutical industry, has been running a series of full-page newspaper adds warning against the proposed plan. The plan will, in fact, provide needed savings in a health care system that is threatened by government spending cutbacks. The Medical Reform Group endorses the B.C. plan, and warns the public not to be misled by the partisan and heavily financed reaction by the industry. ◆

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ments in our society to have an even greater voice in positive social and political change.

The Steering Committee will be taking these items to the fall retreat, and invites members to prepare any comments for that meeting or the next issue of *Medical Reform*. ◆

Hospitals main expense in Canadian health care

The Globe and Mail

The single largest chunk of each dollar Canadians spend on health care is the 38 per cent that goes to hospitals.

That may change as non-invasive surgery and other medical advances, as well as the drive to save money, make hospital stays shorter or even unnecessary.

For now, however, hospitals remain the chief expense — and for many, the main symbol — of the health-care system.

Wellesley Hospital, an aging red-brick institution on the eastern side of downtown Toronto, is a teaching hospital of 384 beds. It offers the full range of services of a general hospital (except pediatrics, which are handled in central Toronto by the Hospital for Sick Children).

In addition, it has three main areas of specialization: diseases of the immune system, minimally invasive surgery and urban health.

Wellesley's operating budget for 1995-96 is $128-million. Here is how that budget breaks down, in percentages:

Salaries	
Nursing inpatient	19
Administration and support	16.3
Ambulatory	7.6
Diagnostics and therapeutics	11.8
Other	2.2
Benefits	10.9
Medical staff remuneration	1.1
General supplies	16.1
Medical/surgical supplies	5
Drugs	5.9
Depreciation	3.4
Rental/lease of equipment	0.3
Bad debts	0.3
Amortization	0.1

August 21, 1995

Privatizing Health Care: No Debate Needed

The MRG issued the following media release on July 5

Yesterday, the Canadian Medical Association wisely chose to reject a resolution calling for user fees and a two-tiered health care system. Although the vote was close, the delegates who rejected the resolution should be congratulated for putting the public interest ahead of narrow self-interest.

Unfortunately, the delegates passed a resolution calling for public debate and discussion about privatization. Such a debate is not only unnecessary, it will be destructive.

First, calling for a debate implies that there is a serious division of opinion. The Canada Health Act, legislation that enshrines universality, was passed unanimously by Parliament. Polls consistently show that Canadians overwhelmingly support our medical system, and the principle of universality.

Second, calling for a debate implies that privatization may solve the problems of the health care system. These problems are a result of inefficiencies within health care delivery, and cutbacks in federal transfer payments to the provincial governments which threaten the health of Canadians both through cuts to social programs, and restriction of health care funding.

We know the effects of privatization, and they will not address these problems. We see what privatization does when we look at the United States. There, we see a health care system that is far less efficient and more costly than ours, and leaves many without adequate coverage.

We see what privatization does when we look at dental care in Canada. Visits to physicians are virtually identical across income groups in Canada. Within the privatized dental system, however, Canadians in the lowest income quintile are only half as likely to see a dentist as those within the top quintile. Privatization will only lead to more, not less, money spent on health care. The money will be spent less equitably, and the poor, already threatened by social service cutbacks, will suffer further.

Third, we need a debate about some real solutions, and arguments about privatization draw us away from this debate. Issues that need discussion include understanding the link between poverty and poor health, and the reduction in social expenditures and poor health. We need to debate how we can persuade our federal politicians to stop transfer payment cuts. We need to address inefficiencies in the health care system, particularly those caused by the fee-for-service system that prevents effective management, while reinforcing unnecessary health care delivery.

The Medical Reform Group congratulates the Canadian Medical Association for their rejection of two-tiered health care. We call on them to stop the destructive and wasteful discussion, and move on to address some real solutions to very real health care problems. ◆

A Capitation-based Primary Health Care System: A Major Step Forward

The MRG issued the following media release on September 1

During the last two days, the Globe and Mail has reported the release of a report recommending a major change in the structure of funding for health care in Canada. The report would change the basis of reimbursement away from fee-for-service, and to capitation. The Globe and Mail correctly reported that doctors' organizations, including the President of the Canadian College of Family Physicians, are largely opposed to the ideas in the report. The Medical Reform Group, however, is strongly supportive of these ideas.

In a capitation-based system physicians would be reimbursed according to the number of patients on their roster, irrespective of the number of visits those patients made. Thus, for a particular patient, reimbursement would be identical whether patients came for many visits during the course of a year, or no visits at all. This system is in many ways the opposite of the fee-for-service system that currently dominates primary care in Canada, in which physicians are reimbursed for each item of service they deliver. Therefore, the more visits the patients make the more money physicians receive. If patients don't visit the doctor, the doctor makes no money.

A capitation-based system would have many advantages. First, the incentive to

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Medical Reform Group Challenges Marleau to Stand Firm on Medicare

The MRG sent the following open letter to Dianne Marleau on September 18, on the eve of the federal/provincial meeting.

Dear Ms Marleau: The Medical Reform Group of Ontario wishes to congratulate and encourage you in your fight for maintaining the principles of the Canada Health Act. We are a group of physicians who believe that health care is a right and the health care system must be maintained to provide universal, high quality health care to all Canadians. While we cannot support your government's cuts to provincial transfer payments and the possible weakening of your ability to enforce the Canada Health Act due to the aggregation of provincial transfers into the Canadian Health and Social Transfer, we wish to continue to support you in your efforts to maintain and enforce the principles of the Canada Health Act.

With the upcoming Federal-Provincial Health Ministers meeting we expect you will be under some pressure to enter into discussions of decreasing enforcement of the Canada Health Act. As in the past, we encourage you to continue to fight for these principles which are the only way to ensure universal health care

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Medicare works best if the affluent are forced to defend it

Philip Berger

Earlier this year a 45-year-old man came to see me complaining of severe burning pain in his abdomen. He had moved from a fishing village in Newfoundland to Toronto about 25 years ago. He was employed as a well-paid shipper in a Toronto suburb for 10 years until an occupational injury damaged his brain. After a partial recovery, he worked for 10 more years in steadily lower paying jobs as a factory-floor cleaner, a street-flyer delivery person and, in the end, a gas jockey. He was fired from his last job and is now on welfare. The combination of his brain injury and an increasing dependence on alcohol plunged him into the ranks of the unemployable.

I referred the dyspeptic man to a well-known gastroenterologist at a downtown Toronto teaching hospital. Within two weeks of the man's visit to me, he had seen the gastroenterologist, had undergone a gastroscopy (a tube inserted into the stomach) and been diagnosed and treated for a stomach ulcer. No conditions were attached to the man's care: no assignment to a public rather than a private clinic, no limit on his health insurance coverage and no delay in treatment based on ability to pay.

The unemployed Newfoundland émigré had received the same care I would have received had I sought help for burning pain in the abdomen. The difference between me and my patient is that, if I couldn't get proper care, I could and would use my wealth, education, my connections and my experience — in short, my political and class power — to ensure that I received the prompt and high-quality service that flowed to the former shipper.

During the annual meeting of the CMA in Winnipeg last week, some delegates declared that citizens would have the right to purchase health care the same way they buy SkiDoos or expensive cars (a comparison made by a Sudbury physician). Another delegate spoke of "empowering" wealthy citizens to buy medical care. One delegate proposed that the less privileged be provided with vouchers to shop around to medical care from private insurers eager for business.

Some CMA proponents of privatization argued that we do not now have a universal system. In the strictest sense they are right: Those with connections and influence (for example, doctors will always advance more quickly to secure services and care. An insignificant few will choose to buy their way out of Canada's system and purchase services in the United States.

But the small number of those with connections and those who flee to the U. S. do not justify labelling our current system as two-tiered. "Two-tiered" customarily divides society into distinct classes, and that we do not have in Canada's health care system. The minor and unavoidable differences in access to that system don't support a wholesale privatization of health care in this country. To their credit, the CMA delegates defeated a motion that called for the right of people to buy medical services as they would other commodities.

Doctors provide for the security, well-being and integrity of everyone in society. Their services cannot be equated with consumer prod-

ucts that people buy for fun or leisure. Physicians' services do not belong in the market place to be flogged like attractive machines at the best price for those who can afford the expense. Doctors are selling health and life. Their wares cannot be given a value on the free market.

State intrusion into the free market is generated by the tension between the public good and private rights. In Canada there are restrictions and regulations in such areas as communications, insurance and energy, because for highly valued services, the state must protect citizens from monopolies, unilateral actions and social inequities. It can do so only by infringing on the private rights of individuals and corporations.

The right to health care has been accorded the highest social value in Canada, equivalent to mobility rights or the right to be treated as an equal before the law. Health care, in the form we have known it, will remain a right only if those of us with influence and political power are forced to defend it. That can happen only if the powerful are regulated into a universal system.

Compelling all citizens into a publicly funded system guaranteed for the majority a standard of care expected by the affluent who in a private system would normally purchase that same standard of care. The affluent will ensure that the standard is upheld for everyone else, because they will have to if they themselves want to benefit from the publicly funded system. Denying the right to purchase private medical care is a small and justifiable restriction on individual liberties if the objective is comprehensive medical care for all citizens.

The CMA did well to oppose privatizing Canada's health care system. The poor and sick can rest at ease, at least for now.◆

Reprinted from Globe & Mail, August 21. Philip Berger is a founding member of the MRG

Capitation-based...

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deliver unnecessary care which is part of the fee-for-service system is removed. Physicians are rewarded for being efficient, and keeping their patients well. Unlike the fee-for-service system capitation provides considerable scope for rational, advanced planning of resource allocation. Monitoring health status can be done more easily, a broad view of health needs encouraged, and interventions targeted to a community's needs. Capitation could positively influence the distribution of physicians, encouraging practice in under-serviced areas.

At the same time, capitation holds advantages over salary-based systems. These include the fact that physicians can retain their self-employed status and their autonomy. In addition, maintaining a larger patient roster, (and, potentially, working harder) is financially rewarded.

The traditional medical associations are short-sighted in their rejection of capitation-based models. The Medical Reform Group calls on provincial governments to move forward quickly in planning the evolution toward a capitation-based system of primary health care delivery.◆

The doctor won't see you now

by Rosana Pellizzari

Once again, the Ontario Medical Association has taught Ontarians a few lessons. In case memories of the 1986 doctors strike over extra billing were beginning to fade, the orchestrated closing of physicians' offices on certain days this month — purportedly in line with Ontario's social-contract law, which requires public servants to take several days off without pay — has reminded the public that the OMA is ready to withdraw services to make political points. While the association may be trying to send a message to the government and the public about physicians' reimbursement, the lessons from its move are likely to differ from the ones it intended.

First lesson: The OMA is not yet ready to work co-operatively to solve health care programs.

Two years ago, the association signed an agreement with the Ontario government specifying caps on the amount doctors can bill in the province: $3.9 billion in 1994-95, $3.8 billion in 1995-96. If the caps are exceeded, the government is entitled to "claw back" the extra.

The OMA made only a limited attempt to reduce doctors' billing, and the result was that the billing substantially exceeded the cap. In response, doctors have walked out of negotiations with the government and unilaterally withdrawn services on the so-called Rae days, an approach with which the government would never have agreed.

There were many ways doctors could have reduced billing without significantly compromising patient services. They could have reduced office hours or rotated taking days off while ensuring adequate coverage for their practices. Instead, the OMA adopted the most visible and public strategy possible, penalizing patients in the process.

Second lesson: The fee-for-service system is unfair and unmanageable.

In our health-care system, most doctors are reimbursed according to the number of patients they see and the number of procedures they perform. This gives them an incentive to deliver unnecessary services. The government, required to manage the system, can control physician costs only through a global billing cap.

Ontario's doctors knew that uninhibited billing would break through the cap, but that didn't stop them from increasing services. The OMA rejected a clawback mechanism that would have penalized higher-billing physicians, or those who had increased billings in the past year, so the clawback applies proportionally to all physicians. As a result, doctors who are responsible enough to maintain or decrease their billing are the most severely penalized, while those who increase their billing build a cushion against the clawback; they are rewarded for heeding the siren's call of revolving-door medicine.

Third lesson: There are better ways to manage the health-care system.

Many of Ontario's doctors are reimbursed in ways that don't involve a fee for each service. Family doctors have organized health service organizations (HSOs), which pay them a monthly rate based on the number of people registered with the practices. This "capitation" minimizes the delivery of unnecessary services, decreases duplication and creates incentives to provide more accessible and appropriate care.

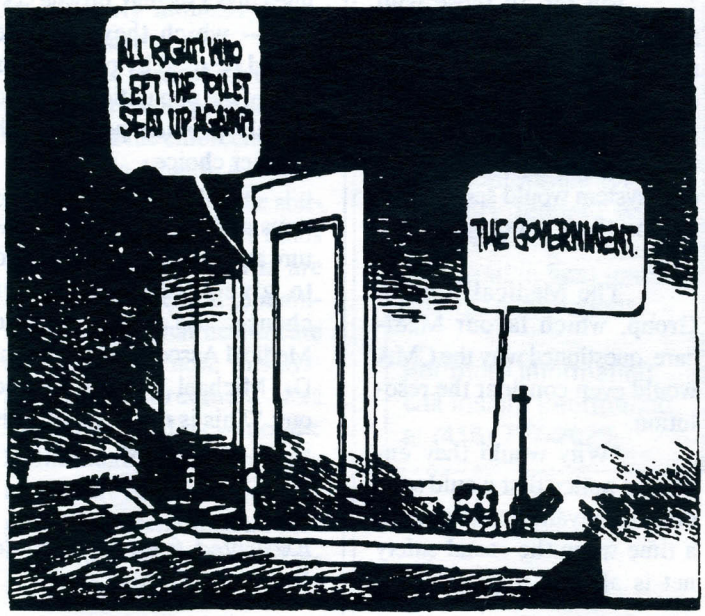
Other family doctors work on staff at community health centres (CHCs) where

they are salaried employees. Ontario has 77 HSOs and 56 CHCs, some in existence since the early 1960s. Such blended methods of payment are common in other countries with publicly funded health care. Salaried doctors, multi-disciplinary group-practice registration and "rostering" for accountability and payment are well supported in the literature and in the field.

No wonder health economists, doctors who have studied the system and the Canadian College of Family Physicians have called for a shift from fee-for-service to a blended payment based on capitation or salary. The OMA's failure to meet its contractual obligations and its decision to penalize patients as a result suggest the need for change is becoming more urgent.

Fourth lesson: Some doctors may not be providing adequate care.

The OMA's "Rae Days" show that when doctors close their offices, many fail to make adequate or appropriate provisions for patient care. Many doctors in large urban centres close their offices at the end of the day and leave their patients to fend for themselves. It is not unusual for a patient in Toronto to call her doctor after hours and be told by an answering machine to go to the nearest emergency department.



Fifth lesson: Can doctors learn theirs? As in the 1986 strike , doctors who have heeded the OMA's call have ensured that closing their offices could be a very public, very vocal event. Once again, the OMA is standing against the public interest. And, as in 1986, the result is likely to be a loss of physicians' credibility.

Organized medicine seemed to learn from the 1986 strike. For a number of years, doctors' groups have been working with governments to try to increase the efficiency of our health care system. Progress, however, has been slow. The OMA's withdrawal of services is a step backward.

Cuts in federal transfer payments threaten Canadians' health, both directly through reductions in health care and indirectly through the consequences of reduced social spending. To maintain universal high quality care, there has to be a more efficient system, with alternative ways of paying health care providers.

By systematically withdrawing services, the OMA weakens its role in fighting to maintain adequate funding. Its leaders should reconsider their position and resume a positive role in the struggle to maintain universal high-quality care. ◆

Reprinted from Globe & Mail, August 21

Why doctors flirt with giving Medicare the kiss-off

Lisa Priest

Like a rocky marriage in need of repair, Canada's doctors have voted to give Medicare another chance.

The Canadian Medical Association (CMA) voted 88-68 this week against a parallel, private health care system, sending a clear signal to government that it's willing to give the publicly financed system one last try.

But that could all change if frustrated doctors continue to see health care fiscally squeezed and services denied to patients, warns former CMA president Dr. Bruno L'Heureux.

"Doctors still want to support Medicare, but if there is no movement within government, then they will look for another way," L'Heureux told reporters at the 128th annual meeting.

Many of CMA's 45,000 physicians have been casting amorous glances for years as a second private health care system. Even though what they have at home -- stability, a high income and freedom -- is the envy of many.

It's clear the majority of doctors favour private funding. A recent Angus Reid poll of 500 Canadian doctors found 78 per cent believe private funding was needed.

That's in striking contrast to the view held by the general population. A recent Insight Canada poll of 1,200 Canadians found 61 per cent were against paying for private insurance.

Doctors attribute this discrepancy to the difference between reality and idealism.

The reality, they say, is long waiting lists, limited access to treatment and patients" disillusionment with a system that was always supposed to be fully there for them when they were sick -- and now isn't.

But for all those who see Medicare's flaws, there are many who cling to its strengths, particularly to its guarantee of treatment. They fear a parallel, private health care system would spell disaster for those who need care most.

The Medical Reform Group, which favour Medicare, questioned why the CMA would even consider the resolution.

"Why would they endorse a policy that would seriously disadvantage the poor, at a time when the social safety net is already fraying?' they asked in a news release.

"The only beneficiaries of this change would be certain physicians whose income would increase. It is hard to see any other motivation for the proposal."

At the conference, Dr. Victor Marchessault, a pediatrician, said: "I am against this, as the first ones to suffer will be all Canadian children."

Dr. John Dornan warned that "moneys will evaporate from a publicly funded system." And Dr. Iain Cleator called one-tier medicine "a good, solid principle."

But other doctors argued that a second, private system -- which they estimate would be used by only 15 per cent of the population -- would merely provide people with another choice.

Doctors tend to be cautious and conservative by nature and, in the end, they opted to give Medicare another chance. As former Ontario Medical Association president Dr. Michael Wyman pointed out: "This is not the time, this is not the way."◆

Excerpted from the Toronto Star, August 19.

Open letter to Marleau...
continued from page nine

and prevent a US style health care system from arising within our borders. User fees (couched as administrative or clinic charges), private clinics offering insured services for a fee, and private hospitals offering services to US citizens, all serve to weaken a health care system which is the envy of the world. We expect the pressure on you to allow the health care system to be opened up to market forces will be strong. We expect these forces to come from physicians' groups who have self interest at heart, provincial governments who have budgetary concerns and ideology at heart, and private insurers who have purely monetary concerns at heart.

One issue which deeply concerns us is the possible "delinking" of the enforcement of the Canada Health Act with provincial transfers. The ability to withhold Federal funds when Federal standards are not upheld is central to maintaining a national health care system. Until now, this system of enforcement has worked well and prevented the Balkanisation of Canada's health care standards. Heterogeneity between Canada's provincial jurisdictions would result in the fragmentation and dissolution of the national, portable, universally accessible and universally high quality health care system as we know it. It is imperative that you do not allow any weakening of either the principles or enforcement of the Canada Health Act. This is a critical time for Canada and its ability to maintain its defining social programme. As a group of concerned physicians we encourage you to continue the fight.◆

Insight Globe Conference on Private Initiatives in Health Care

Toronto
December 6-7, 1995.

This conference for 'industry leaders' will feature Rosana Pellizzari in final panel on future directions.

For more information, call Insight Information at (416) 777-2020.

Ontario Hospital Association
Annual Convention
November 6,7,8, 1995
Metro Convention Centre
Theme: Privatization

For more information, call the OHA at (416) 429-2661.

National Medicare Week
October 30-November 3

The Canadian Health Coalition is co-sponsoring a series of community forums across the country to prepare for National Medicare Week. The Southern Ontario forum will feature Buzz Hargrove, President of the Canadian Auto Workers and Rosana Pellizzari.

Tuesday, October 10th, 1995, 7.00 pm

Auditorium, Ontario Federation of Labour Building, 15 Gervais Drive, Don Mills.

For more information, contact Adriana Tetley at (416) 441-2731.

Ten Reasons to be concerned about Block Funding

As announced in February's budget, the Liberal government has introduced legislation that threatens to undo two generations of social policy. Bill c-76, tabled March 20 by Finance Minister Paul Martin, outlines key amendments to the Canada Health Act and the Canada Assistance Plan (CAP). It proposes the creation of the Canada Health and Social Transfer (CHST), a block grant to replace current transfer payments from Ottawa to the provinces for welfare, post-secondary education and health. Under the new scheme, provinces will receive far less money with fewer conditions on how the money is spent.

Here are ten reasons Canadians should be concerned:

1. The CHST drastically reduces social spending. Between 1996 and 1998, ***provinces will receive $7 billion less than under current arrangements.***

2. Consequently, ***cash-strapped provincial governments will be forced to further slash spending on health, post-secondary education, and social services.*** That means a continuing decline in the quality of health care, an increase in university and college tuition fees, and an erosion in essential social services.

3. ***Medicare is directly threatened.*** Ottawa uses its spending power to ensure provinces comply with the principles of the Canada Health Act and provide Canadians with accessible, portable, universal, comprehensive and publicly administered health insurance. But under the CHST, the cash portion of federal transfers will steadily decline to $0 by the year 2008. Ottawa will soon be unable to withhold cash as a way of punishing provinces which permit extra-billing or the de-listing of medical services.

4. Because block funding comes with few strings attached, ***there is no guarantee that federal funds allocated for social programs will not be spent elsewhere.*** Money intended for health care or social assistance could conceivably be used to pave provincial highways.

5. ***Block funding provides no assurances that provinces will contribute to social programs.*** Current arrangements under CAP require that provinces make an initial contribution to social services. The CHST contains no such condition.

6. ***Provinces will not be required to have a last resort income safety net in place.*** Under CAP, all provinces, in order to qualify for federal money, must provide income assistance to any citizen in need. The CHST repeals this.

7. ***The CHST will allow provinces to implement 'workfare.*** Forcing people to work for benefits not only violates a person's right to refuse dangerous or degrading work, but it also has terrible economic consequences for all Canadians. When people are forced to work for very low wages, there is a ripple effect throughout the whole economy, and all our wages becomes depressed.

8. ***Block funding betrays future generations.*** When we invest in people through social programs, we are making an investment in the future social and economic health of our nation. By slashing away at health care, education and income assistance, the CHST will make us a much poorer society.

9. ***Block funding threatens national unity.*** With the loss

of national standards, a ragged patchwork of social programs will spring up across the country, leading to greater regional disparity and inequality.

10. ***Block funding represents constitutional change by stealth.*** By withdrawing the federal government's presence from social policy, block funding ushers in the kind of decentralized federalism the majority of Canadians rejected in the Charlottetown Accord referendum.

What can you do?

Write, phone, fax or meet with your federal MP and voice your concern about the future of health care, post-secondary education, and social assistance. Write to your local newspaper and let your community know about the dangers of block funding. Press your provincial and municipal politicians to pass resolutions condemning the CHST. Speak to your neighbours, coworkers and friends and tell them why they should be concerned. Together, we can defend the social programs that are a distinguishing feature of Canadian life.◆

Reprinted from Canadian Perspectives, Summer 1995

[Bill c-76 passed final reading, essentially unchanged, in late summer, 1995.]

Welfare Fightback

Welfare advocates have launched the first of a series of court challenges on the cutbacks proposed by the new Harris government. Although Madame Justice Janet Boland ultimately denied the September 29th attempt by 12 claimants and their advocates to secure an interim injunction to prevent the cuts being implemented on October 1, 1995, she has called for a special hearing November 6th, for both sides to present evidence on whether the regulation [setting out the new rate structure] should be struck down.

The ad hoc group of advocates will be seeking additional evidence of the impacts of the cuts over the next weeks, and will also be preparing for a series of further legal challenges over the fall and winter on other recent changes, including 'spouse in the house', the elimination of welfare for teens, and privacy issues relating to the 1-800-snitch lines. In addition to identifying appropriate claimants, members may be able to assist in identifying expert witnesses or information which could support any of the challenges.

For more information, call Melodie Mayson, at Neighbourhood Legal Services (416) 861-0677.

An Experience not to be Missed

Bob Frankford

According to Dalton Camp, one of my favourite political writers (who is generally noted to have become a social democrat by means of a heart transplant) the only people who are assured of re-election to political office are family doctors and politicians' widows. Alas I was wrong on this one, as I found myself being defeated in the June 1995 election after four and a half years at Queen's Park.

Before 1990, my involvement in elected politics was virtually non-existent apart from being on the Community Advisory Board of the Eastern Area of the City of Toronto Board of Health. I had occasionally canvassed in elections for candidates I liked, but I was quite surprised to be solicited to run in Scarborough East. I asked one-time candidate Ty Turner, for advice and he said that an election campaign was an interesting life experience and worth adding to one's CV.

My experience clearly reflects one government at one particular time. No doubt every period of office has its own characteristics according to the individuals, issues of the day, leader and public mood of the time. There were times, such as having to listen to harangues by my least favourite opposition members, when I wanted to be somewhere else, but the privilege of being involved in some small way in the history of the province more than compensated for those less than pleasant moments.

Where do initiatives for action come from? The outside world tends to ascribe it all to the government, while those inside look more to individuals or groups. Within government, there is the question of whether elected officials or bureaucrats initiate change. By their nature, health services are important issues for local constituencies and individual members will always be involved in advocating for new services of defending old ones. This clearly is an area where the local member will be working with local interests and becoming knowledgeable on health issues. The downside is that this advocacy tends to be in relation to institutions and commonly is about capital projects - CAT scanners, etc. Besides this sort of advocacy it is common to hear from proponents of particular drugs, diseases, treatments, etc., who probably have a greater impact on non-physician politicians.

When it comes to legislation, the interplay of driving initiatives becomes complex. Major health related legislation we proceeded with had been developing over a long time, with impetus from the political level and bureaucracy. Health professions legislation, long term care and tobacco legislation are examples that come to mind.

Aside from trying to persuade the caucus regarding one's own issues, there are subtle ways to gradually push them forward. An individual member can communicate with ministers and their political staff, can make members' statements (only 90 seconds allowed, but the choice of topic is at one's own discretion), ask questions, present (and help draft) petitions, and put out press releases. In some ways it probably is advantageous being a backbencher because of the lack of constraints associated with particular portfolios.

Every Thursday when the House is sitting there is private members' public business. Members ballot for one of the two hour slots and can

introduce their own bill or motion for debate and a vote in the house. It is an opportunity to raise awareness or suggest some needed legislation, although realistically private members' bills never become law. I had a slot early in the term and introduced a motion call for no-fault compensation for vaccine damage.

Before being elected, the MRG had given me a little experience at Queen's Park through presentations to legislative committees. Having now seen the process from both sides, I believe these are valuable opportunities to put forward positions, to get a sense of the approaches of all political parties and to build credibility. The MRG frequently presents for matters in which it obviously has something to contribute such as professions legislation, long term care and independent health facilities. There are other committees (of which I was not a member) such as Economics and Finance which may not be so inclined to invite the MRG, but which should not be ignored as a platform for the presentation of alternative views.

I was a member of the Public Accounts committee throughout my term. This committee works with the Provincial Auditor and uses the Auditor's annual report as a basis for discussions, picking out particular topics to investigate at some depth. Over the years, we discussed health matters like the Toronto Hospital and its accountability, and OHIP registration and health cards. Outside delegations like the MRG has limited opportunity for involvement in these discussions. The transcripts of the hearings are quite fascinating, and MPPs get comprehensive briefing documents, that would be of considerable use in developing public understanding.

How to influence politicians and policy makers is a question that supports a significant industry of consultants and the staff of numerous advocacy organizations. Maybe I wasn't important enough, but I did not find people clamouring to take me out for expensive lunches. It seemed to me that well thought out letters — particularly from one's own constituents — did make an impact, as did meeting with delegations. And on the principle that for every call or letter received there was a multiplier of the people who never got round to communicating, it was apparent how advocates could amplify their message.

Meetings with delegations in the constituency office or in the member's office at Queen's Park are useful ways of interacting and raising awareness. Sometimes these are part of highly organized lobby campaigns across the province, with local members of provincial organizations presenting a position to MPPs. Ministries carefully clip letters to the editor and count the number of letters that they receive on particular topics. It's also generally felt that multiple form letters have less impact that a few well thought out personal letters.

So-called case work is a significant part of the MPP's constituency work, and it makes one realize how much the provincial level of government relates to the concerns of everyday life. Being a family physician is invaluable training. There are considerable similarities in the needs to take histories, come to plans of action and hopefully send clients on their way feeling somewhat better. Common and often difficult cases include housing and Workers' Compensation and other employment -related problems

Friends and family have commented that they never imagined the range of matters that MPPs could be involved with. Having been there, I would not minimize the importance and potential of involvement in trying to make the democratic process work.◆

Canadian Council on National Issues

Ian Scott

On Saturday June 3, steering committee member, spoke on health and health care at the CCNI Conference, "Canada and Country II: Alternative Policies for a Strong United and Sovereign Canada." The topic of the conference was mending the social safety net. The Canadian Council on National Issues (CCNI) was founded in 1994 to pursue a "balanced and progressive society through public policies ensuring that our people and resources are treated honestly, with fairness and dignity". This council appears to involve many individuals from Mel Hurtig's National Party.

Speakers included Michael Babad, Associate Managing Editor, Report on Business for the Globe and Mail, William Krem, publisher of Economic Reform and David Pfrimmer of the Ecumenical Coalition for Economic Justice.

The conference began with a keynote address from Michael Babad, who highlighted his recently published book Where the Buck Stops: the Dollar, Democracy and the Bank of Canada. His main thesis is that the Bank of Canada was originated to stabilize Canada's economy for all citizens yet the Bank has lost its way, particularly under its two recent governors. John Crow and Gordon Thiessen's attack on inflation has maintained high unemployment and poor economic growth at the expense of low rates of inflation. Babad posits that the Bank must consider its original tenets and consider unemployment and economic growth when setting monetary policy (particularly interest rates).

The discussion then moved on to health and health care. My presentation covered the history of Medicare, physician payment models, the Canada Health Act, user fees, the pharmaceutical industry and a conclusion that was congruent with the day's theme that economic policies have significant impact on the health of Canadians. I used the example that the direct and indirect cost of 10% unemployment results in $106 billion to Canadians in lost revenues, UIC payments, and health and social service benefits. In addition, the huge social burden measured by increased morbidity and mortality is not captured by this monetary value.

The audience was very receptive to MRG positions on the above topics and a transcript of the talk was published in a monograph. ◆

National Forum on Health

The 24-member National Forum on Health, appointed Prime Minister Jean Chr_tien last year to come up with innovative ways to improve the health of the population released a 16 page discussion paper, "The Public and Private Financing of Canada's Health System, " to clarify issues in the debate on Medicare. The National Forum will shortly be setting up 1-800 numbers across the country to solicit Canadians interested in participating in study circles and local town hall meetings to find out what's wrong with Medicare. The Prime Minister has asked the National Forum to report back to him on their findings within two years. September 8, 1995

LINDA MCQUAIG'S SHOOTING THE HIPPO:

A summary by Ian Scott

Linda McQuaig has come under considerable fire from the mainstream media for her most recent foray into popular economics. What is offered here is a short summary of some of her analysis on the universality of social programs, the debt, inflation and unemployment.

1. The Marketplace Economy of Health and Social Services

The elite in Western countries, now richer than in previous centuries, feel that they are paying more than they are receiving. The elite therefore wish to return to an economy which will distribute resources on the basis of what is earned (no automatic rights). The return to an historical marketplace economy for such items as health and well-being is a way to save the rich from contributing to the health of the poor.

The argument for cuts to health and social services is often framed as "cut backs will reduce the 'dependency' the poor have on hand outs". What is often omitted from this, albeit specious, dependency argument is that organized societies are founded on mutual dependency. Common roads, hospitals, garbage collection, are what make organized societies efficient and effective systems.

Therefore, while a marketplace economy which allows individuals to purchase health and social services may be more efficient (cheaper) for the rich, it will not be more efficient for society as a whole and will lead to great suffering amongst those who do not have the resources to purchase goods and services.

2. The Debt Crisis

Two possible solutions to the debt crisis are available (if as severe a crisis exists as we are led to believe):
cut spending (usually social spending is the target) increase taxes

Why have cuts to social spending been the predominant view? The upper and middle class who least need social supports have the majority voice in all media. All media outlets are owned by the "elite" with the majority of writers and broadcasters reflecting the views of the "elite" due to their membership in the "elite" or being influence by the "elite".

In Canada, the CD Howe Institute also contributes to the dialogue while masquerading as an impartial academic body. The CD Howe Institute is in fact funded by large corporations including the 5 largest banks in Canada. This hidden association with the elite and their corporations allows "ideas laundering".

3. How Did The Debt Get So Large

Vincent Truglia, of Moody's Investors Services notes, that Canada's former AAA rating (the top rating) indicated a risk of default of 0.3% over 10 years. The downgrading to AA1 indicates a risk of default of 0.5% over 10 years which is still amongst the world's top 24 nations.

Only 6 corporations have an AAA rating worldwide. In 1993 Moody indicated that Canada's debt was grossly over-exaggerated. It should be remembered that the estimated debt prior to the Liberals first budget was $30 billion which jumped to $45 billion after the budget was brought down. Why were so few in financial circles concerned for this jump This exaggeration of total debt was

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due to the Federal Government's accounting method of including the debt of all crown corporations (for example, hydro projects), and capital investment (infrastructure).

In fact most of Canada's debt is profit generating. Our system of public accounts makes no distinction between operating expenditures and capital expenditures. Few if any private corporations would have a positive balance sheet if they used the same accounting procedures as the Federal Government. Some argue that social program spending should not be included as debt as this spending is also a form of infrastructure spending.

At the same time, Canada does have a deficit and it is large. Our current annual revenues are $10.4 billion more than we spend but we must spend an additional $42.5 billion on interest payments to service the debt. Since social programs are being targeted for cuts to help reduce the deficit, how much did they contribute to the deficit?

A 1991 report by Hideo Mimoto published in the Canadian Economic Observer calculated how much expenditures had increased between 1975 and 1990 for a number of social programs and how much these increases contributed to the deficit:

UIC contributed to a 1% growth in the deficit OAP contributed to a 6% growth in the deficit Welfare contributed to a 4.5% growth in the deficit Protection of persons and property contributed to an 8% growth in the deficit Family Benefits contributed to an 11% reduction in the deficit Public transport and communication contributed to an 8.2% reduction in the deficit

Overall, spending on social programs has not been growing any faster than the growth of the economy—the percentage of the GDP spent on social programs has not changed since 1975.

The real culprit in driving up the deficit was the recession. The legacy of the recession is unemployment,

Unemployment may kill, doctors say

Tor Star Sep 9 95 B1

By Eric Beauchesne
SPECIAL TO THE STAR

Job creation sputters, but some analysts see signs of growth, B3

OTTAWA — Unemployment may be a killer and must be arrested, a team of Canadian doctors concludes.

Evidence that unemployment can result in sickness or even death is strong enough that offsetting its adverse impact should be a priority, three doctors argue in a report in the latest issue of the *Canadian Medical Association Journal*.

"We found that the evidence strongly supports an association between unemployment and a greater risk of morbidity (physical or mental illness or use of health-care services ... and a greater risk of mortality ... " they said.

The report by Robert Jin of the B.C. Workers' Compensation Board and Chandrakant Shah and Tomislav Svoboda, with the University of Toronto, draws on 15 years of global research into the relationship between unemployment and health.

Most studies found that increases in mortality rates due to heart disease and suicide accompany rising unemployment and that there were higher mortality rates among the unemployed than among the employed or the general population.

And the findings of at least one study suggested "longer-term unemployment is more harmful than short-term joblessness," a particularly disturbing finding in light of the sharp rise in long-term unemployment in recent years.

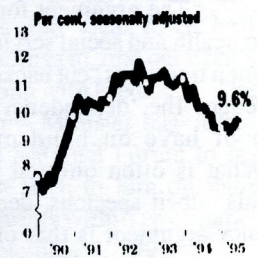
"Workers laid off because of factory closings have reported more symptoms and illnesses than employed people; some of these reports have been validated objectively," the study says.

"Unemployed people may be more likely than employed people to visit physicians, take medications or be admitted to general hospitals."

SOUTHAM NEWS

Job market little changed

Canada's unemployment rate declined to 9.6 per cent last month from 9.8 per cent in July.



SOURCE: Statistics Canada

which is currently estimated to cost Canada $109 billion per year. Stripping away the recession component of the debt, as calculated by the OECD (Organization for Economic Co-operation and Development) the structural (non-recession induced) Canadian debt is 2.1% of the GDP, higher only than Japan. It is the recession, not spending which has generated the Canadian deficit.

While the structural debt in Canada is low, its level reflects a reduced commitment to infrastructure spending over the last 2 decades. Infrastructure spending has decreased in Canada from 4% in the 1950's to 2.5% in the 1990's. This reduced spending on infrastructure will itself hamper any economic recovery should it occur. If the recession has contributed so much to the Canadian deficit, why has the recession been so strong in Canada?

4. The Role Of The Central Bank's War on Inflation

In 1987, Bank of Canada governor, John Crow announced an increase in interest rates which initiated the recession of the late 80's. The Bank of Canada loans money to financial institutions who in turn loan money to the public. The amount of money the Central Bank puts in circulation has a large influence on interest rates.

In any economy there is a tension between growth on one hand and inflation on the other. In times of high growth, inflation rises, with rising prices and wages, and assets being devalued. In times of low or zero growth, inflation is low, prices and wages are stable, and assets maintain their value. In essence, the tension is between those with assets and those who wish the economy to grow.

One may ask, who therefore benefits from high interest rates? Creditors are the major beneficiaries of high interest rates and therefore the financial community benefits from the war on inflation. Bond traders and money speculators benefit immensely during times of high interest rates. Business suffers somewhat when interest rates are high as growth for them is also more difficult. Still, wages are held to low or no increases and the investments that most large businesses have grow during times of low growth due to high interest rates. Workers on the other hand need a strong economy to stimulate job opportunities and benefit little from high interest rate investment returns.

While interest rates appear moderately high, it is the real interest rate which is particularly high. The real interest rate is the differential between interest rates and inflation. Real interest rates in Canada are at an all time high. In the 1970's real interest rates were 1.2%; between 1990 and 1992, they were 8%, and in 1994 they were 6%. Canadian real interest rates are the highest of the G7 Countries (some 4 to 6% greater than US rates, for example).

Canadian economist, Pierre Fortin, estimates that $20 billion of the $49 billion debt is due to lower tax revenues due to the recession. Another $10 billion of the debt is estimated to be due to increased social assistance costs. A full one-third of the remaining $20 billion of the debt is needed to service the interest on the debt itself-a debt which resulted from a deliberate policy of maintaining high interest rates.

The government response to high interest rates and a low growth economy has been to cut social programs, programs that have had little to do with the increased debt. It is these social programs which are needed to allow Canadians to weather the current recession until interest rates are lowered and the economy is stimulated.

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Summary

- The increased debt has not been due to increases in government spending since spending on all Federal programs during 75-76 was 19.7% of the GDP and dropped during 1992-93 to 17.8% of the GDP.
- Real interest rates in Canada are very high and are the highest of the G7 (7% in December, 1994) High interest rates choke the economy and increase the debt. Interest payments on the debt were 2.3% of the GDP during 1975-76, and increased to 5.7% of the GDP during 1992-93
- By the late 80's Ottawa was collecting $10.4 billion more than it was spending on programs but needed and additional $42.5 billion to service the debt.
- The debt was not caused by increase spending on social programs (UIC contributed to a 1% increase in the debt while interest payments contributed to a 70% increase in the debt).
- Interest rates are also high due to outside forces (Japanese real estate crash of 1994 withdrew 10 trillion from world investment markets) but Canada still has a great deal of control over its interest rates.
- Large deficits do cause interest rates to rise but Canada still has an excellent bond rating (AA1) Artificially high interest rates serve the financial elite and are the result of the "failed" experiment to keep inflation between 2-3%.

Therefore, the central bank must be instructed to lower interest rates thereby stimulating the economy.

- This action would increase revenues and lower the debt due to increased taxation revenues from a growing economy.◆

OHA under scrutiny over Blue Cross sale

When the Ontario Hospital Association announced the sale of its non-profit insurance carrier late Blue Cross late last year to US insurance giant Liberty Mutual, groups including the Ontario Federation of Labour and the Ontario Health Coalition demanded the government stop the process and investigate the issue, on the grounds that public money — the fees paid by Ontario hospitals to belong to the Ontario Hospital Association — might be involved. Then-treasurer, Floyd Laughren, declined, on the grounds he had no jurisdiction to pursue the matter, and the sale was finalized in February, 1995. Now, it appears that OHA president and chief executive officer Dennis Timbrell and two other senior staff received special payments adding up to nearly $1 million in as a result of the sale. When the OHA board had second thoughts and attempted to retrieve the special payments, Timbrell refused. He was asked to resign, and did so on September 14, 1995, but not without asking for a public inquiry into the sale.◆

September 20, 1995

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Broadens Its Agenda

Gordon Schiff MD

At the spring meeting of Physicians for a National Health Program May 20-21, the following strategic priorities were set:

PNHP: More than a "Single Issue" Organization. The work of PNHP ought to be broader than just "Single Payer" advocacy. Without losing our historic identity or support for a universal publicly financed system, we need to extend our work to counter the corporate transformation of health care, as well as broaden our definitions of health and health care. The new PNHP slide show (available this fall) will focus on socio-economic factors that influence health and the corporatization of health care.

Need to redefine what "Single Payer" Means What would public financing of a system dominated by large for-profit horizontally and vertically integrated firms and chains look like and mean.

Expose Corruption of Medical Profession/Leadership While many physicians are under severe economic and professional attack, others are being co-opted into lucrative collaborative relationships with the very firms who are ravaging the health care system. We need to challenge medical society and primary care MD entrepreneurship, which is trading patient care advocacy for physician materialistic self interest.

Articulate Appropriate Outrage in Response to Attacks on Patient Health & Welfare. The economic, political and health gains of decades of the civil rights and labor movements are under severe attack. While the full impact of these attacks are only beginning to be felt, their literally murderous consequences call for infusing a sense of urgency and militancy into PNHP's work

Medicare & Medicaid: Only Solution is System Reform Neither incremental reforms nor wholesale cutbacks offer a solution to budget shortfalls. Need for us and our allies in cutback struggles to infuse the single payer perspective into this current debate.

Key Allies: Nurses, Students The employment futures of these health professionals are under severe attack, and there are growing threats to their ability to perform their jobs well. Growing militancy and eagerness of nurses to link with PNHP calls for concerted efforts on our part to work/strategize jointly.

Expose/Oppose Corporate Takeover of Health System The rapid transformation of the system with the concentration of power in the hands of for-profit firms is inimical to health care needs. Impacts go beyond simply draining off their 30% for profits, marketing, administrative waste, mergers and acquisitions. It is leading to growing polarization, transformation of values, exploitation and neglect of community health care needs. PNHP can play a unique role to develop this critique, including the impact on clinical care.

Failure of Managed Care —Fee-for-Service Not Our Alternative. Managed care has been the vehicle for corporate takeover of clinical medicine. New financial relationships shift financial risk to providers and lack the positive features of the original

continued on Page Twenty-Six

Telling the Truth About Medicare

Diane Lardie

Medicare is going bankrupt... We're going to save Medicare." That's the message the Medicare Communications Group, a project of the House Republican Conference, would have the public believe. The people, still confused after last year's health reform complexities are: (1) fearful of losing a program that is a literal lifesaver; (2) desperate to protect benefits yet concerned about deficit spending; and (3) mistrustful of any "solutions" out of Washington. It's truth time again.

First, Medicare is NOT going bankrupt It operates out of a trust fund with earmarks spending for present and future. There is nothing "stagnant" about a trust fund, and the Medicare trust fund has been adjusted several times when needed. The difference now is that the Republicans via their "Contract" have promised a balanced budget and tax cuts for the wealthy. Therefore Congress is being asked to okay program cuts and cost-shifting to the 65+ group. To get the seniors to "buy-in," they must be convinced that Medicare is going broke and that there is no other alternative.

Second, there is no disputing that the Medicare program needs some fine-tuning. That adjustment should be made with the needs of real people in mind, not based primarily on political coups and budgetary factors. Shifting costs (New copayments, higher premiums, higher deductibles) to persons who are already paying 20% of their incomes out of pocket for medical care is unconscionable, especially when the saved dollars will be passed on to those with high incomes and corporations. Where can savings be realized? In payments to medical providers — hospitals, physicians, pharmaceuticals, nursing homes. Steps in this direction in the '80's proved to be effective. This factor is built in to the health plans in other countries.

Unnecessary use of technology is a costly practice. Fraud by providers also needs more careful oversight. In addition, increasing the Medicare payroll deductions should not be beyond discussion. When people understand and feel there is value for the money spent, they overwhelmingly support tax increases. The biggest sham in the Medicare - and Medicaid - discussion, however, is that these domestic programs, which account for half the federal budget are having to take all the cuts. Social security and defense spending are "untouchable." The defense budget was raised beyond even what the Pentagon asked, mostly to manufacture more "I-only-work-when-the-sun-shines" B-2 bombers.

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not-for-profit HMOs. In addition to wrecking continuity and appropriate decision-making, managed care's claim to control costs is erroneous. While allying ourselves with growing dissatisfaction amongst MDs, PNHP needs to clearly differentiate itself from self-serving opposition to managed care and articulate a different vision than merely restoration of fee-for-service.

Gordon Schiff is Past President of Physicians for a National Health Program. For more information, call PNHP at 312-554-0382. ◆

Reprinted from Action for Universal Health Care

Vouchers, a false solution, are being promoted to encourage seniors to join managed care plans. "More choice" seniors are told when in fact the choice is there now. "A fixed voucher will provide windfall profit for private, mostly for-profit managed care plans which recruit healthier Medicare beneficiaries while creating a trap for those with high costs," notes Bob Griss of the Center on Disability and Health. Ninety per cent of people on Medicare use an average of $1,340 per year; yet the average of total Medicare spending is $3,800 because 10% use $28,000. If managed care plans "cherry pick" well and are paid $3,800 per person, there's a fortune to be made. Public money making private millionaires. At the same time, those whose health needs are great will be shunned by the profiteers. The money to pay their bills will have gone.

What then? **Health care justice is hard work. Workers needed. Equal opportunity employer. The time to educate legislators is NOW!**

Diane Lardie is National Coordinator of the US Universal Health Care Action Network. For additional information: 1-800-634-4442 Reprinted from Action for Universal Health Care, September 1995.

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Doctors check national pulse

JANE COUTTS
HEALTH POLICY REPORTER

Last week in Winnipeg, delegates to the Canadian Medical Association's annual meeting agreed that Canada's health care system is in critical condition. What the doctors could not agree on was a cure.

Deep divisions of opinion were clearly established during the three-day meeting, as 202 delegates representing 45,000 Canadian physicians argued over the future of health care.

After an emotional debate, the doctors voted down a resolution supporting the idea of private insurance to cover all medical expenses — insurance which would, in effect, finance a private health care system.

Far from seeing the vote as the end of the issue, however, the doctors went on to endorse a plan to start a national debate on whether private insurance for private medical service would be permitted.

The action has drawn swift criticism from the Medical Reform Group, an Ontario based coalition of doctors committed to preserving Medicare.

Dr. Gordon Guyatt, a spokesman for the group, said "calling for debate implies privatization may solve the problems of the health care system."

What's really needed, Dr. Guyatt said, is to harness public concern over health care into a discussion of the ways in which money is currently spent on health care in Canada, and how that might be made more efficient.

According to the federal Health Department, spending on health by individuals, governments, public insurance plans and private insurers totaled $72 billion in 1993 or $2,506 for each person in the country.

The $72 billion figure given by Health Canada covers: Payments to doctors, nurses and other workers in the health care system; The cost of running hospitals and ambulance services; All medications, prescription and over the counter; Psychotherapy; More than 2.2 million surgeries performed each year; Hearing aids and eyeglasses; Blood transfusions and dental care; The operation of nursing homes; The administration of all insurance plans, public and private.

Also counted as health costs are everything from the $5 a doctor charges to write a letter on behalf of a patient to contact lens solution and latex gloves for a hospital's emergency department.

But other expenses that contribute substantially to the health of Canadians — the cost of prenatal nutrition programs, for example, or home care for frail seniors — might not show up because the provinces that offer them classify them as welfare programs.

When the definition of what constitutes health spending is so wide-ranging, it is not surprising that Canadians are said to spend the equivalent of 10 per cent of their gross domestic product on health care.

That is one or two percentage points more than most European countries spend on health care, and Prime Minister Jean Chrétien's belief in the need to bring it more in line with Europe is what led him to suggest not long ago that only catastrophic illnesses should be paid for by Medicare.

Robert Evans, a health economist at the University of British Columbia says he thinks the percentage of the GDP that Canada spends on health care is now probably lower than 10 per cent. He believes that the recovering economy , combined with a reining in of health care costs, probably has brought the figure more in line with European numbers.

What drove Canada's health care costs out of line was governmental protection of health spending during the disastrous recessions of the early 1980s and 1990-92, Dr. Evans said.

During those years the GDP withered, but health spending continued to increase at a steady clip.

But if governments have overspent on health care through hard times in the past, it is now clear that the 71.9 per cent of spending on health that is financed by the public purse is actually better controlled than private sector health spending.

The public share comes mainly (46.5 per cent) from provincial funds, but 21.7 per cent is covered by transfer payments that Ottawa intends to scale back over the next three years. Transfer payments have been declining steadily for some time: in 1975 the federal government covered 27.5 per cent of the cost of health care through transfers.

None of the provinces covers its health costs entirely through public insurance funds and transfer payments; the balance comes from general revenue.

The federal government also directly finances some health care, the equivalent of 1.8 per cent of total expenditures, for such things as aboriginal and veterans' programs. One per cent of total expenditures comes from municipal programs, and 0.9 per cent from workers compensation schemes.

At the doctors' meeting in Winnipeg, a national survey recently conducted for the Canadian Medical Association was referred to again and again.

It showed that 78 per cent of doctors think user fees should be charged for health care services, the argument being that this would both discourage inappropriate use of the system and help finance it.

But user fees remain unpopular with the public. In another recent CMA survey more than half those questioned rejected the idea.

The counterargument to user fees is that they discourage those less well off from getting needed care, but do little to discourage more affluent people who may be abusing the system.

Physicians received 15.1 per cent of health care outlays in 1993, a slight decrease from recent years, for a total of $10.3 billion. Publicly financed fee-for-service payments are also divided almost equally between specialists and family doctors who also are about equal in number.

Health Canada says hospitals take about 38 per cent of the health care dollar, but half or more of the provinces' health budgets is spent on them.

However, through amalgamation of services, bed closings, day surgery, and a move to ambulatory care, hospitals have done much to trim costs.

As is the case with much health care spending, however, a reduction in hospital costs shows up elsewhere in the health-spending ledger, with the explosion in spending on home care — the visiting nurses, housekeepers and therapists who oversee the recuperation of people discharged after shorter stays in hospital.

More recently, programs such as home administration of intravenous antibiotics are keeping even more people out of hospital who once might have occupied beds for days or even weeks at a time.

Health Canada estimates that 98 per cent of home care is actually paid for from the public purse, with insurance companies covering most of the rest.

In 1980-81, a total of $125.4 million was spent on home care. In 1992-93 the amount was $929 million with annual increases averaging almost 17 per cent over the five years from 1989 to 1993.

Raisa Deber, a professor health administration a the University of Toronto, says the move to home care may only appear to save money.

It's true that if people can be sent home sooner, it costs hospitals less. But the cost of care does not disappear. The hospital may not be paying for it, but someone is covering the costs of the visiting nurses and therapists and the special food, medication and supplies that may be needed., she said.

David Naylor, of the Institute for Clinical Evaluative Sciences at the University of Toronto refers to those costs as "indirect and unfair hidden sickness taxes."

He said there is a further potential cost, both to the individual and to society, in lost productivity when people take time off to care for sick family members who might otherwise be in hospital.

Drugs constitute another sector where spending is growing rapidly.

Health Canada reports that outlays on drugs — both prescription and over-the-counter — accounted for 15.1 per cent of health care spending in 1993. Spending on drugs increased by more than 8 per cent a year in 1992 and 1993, after double digit increases for more than a decade.

More than 6 per cent of health care expenditure goes for wholesale and retail markups and dispensing fees on drugs.

Dr. Evans said the way drug costs have soared when other health care expenses are being brought under control shows one flaw in mixing private and public funding. "Where you get fragmented funding sources, government, insurance companies and private individuals, that tends to be a pretty expansionary environment, because there is no one agency responsible for imposing controls."

Dr. Naylor said drugs may be the last area in the health care system where big savings could be made without profound changes to the structure of the whole system. He said much of the skyrocketing increase in the cots of drugs is due to the steady shift to newer products, even though older drugs work as well for many patients at a small fraction of the cots.

In most cases, he said, there is little evidence that the new drugs bring about substantially more impressive health outcomes than their predecessors. "They do play a role, but they cost a fortune."

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