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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Semi-Annual General Meeting November 18th

Twenty-five members spent a full day November 18th in a strategy session which combined analysis of current issues and a review of resources to meet some of the most immediate needs. While the situation is critical, there remains considerable energy and interest in continuing the battle to maintain and enhance publicly funded fully-accessible health care in Canada, and in Ontario.

In addition to the Statement, reproduced below, members made a number of constructive suggestions which are being systematically followed up by the Steering Committee. These include:

- preparation of a range of fact sheets on issues of interest to members and subscribers, beginning with 2 on the impacts of social spending cuts on health status;

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UNIVERSALITY: CONDITION CRITICAL

Gordon Guyatt

Health care in Canada is under assault. The first recent blow came with the federal government cuts in transfer payments, and the lumping of the social service transfer into a single pot. The cut threatens our ability to maintain universal, high quality health care. It will also result in a further burden, because of the secondary adverse consequences of social service cuts on the health of the poor.

The federal government is, however, ambivalent about the destruction of universal care. This is not through any deep philosophical commitment to equal access, as Jean Chretien and Paul Martin made clear with their statements following the federal budget. These national leaders tested the waters with statements about how Medicare was intended only to prevent disastrous health expenditures, and how private funding may compensate for government health care spending cuts. Fortunately, the public reaction was so negative, that after a couple of weeks of hostile reactions, the Liberals have once again become loyal defenders of national health care.

The federal ambivalence is highlighted in the actions of Diane Marleau. The

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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 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 This Issue: Mimi Divinsky, Rosana Pellizzari, 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.

Statement From The November 18th Semi-Annual Meeting

The MRG recognizes that restructuring of the health care system to improve efficiency, fairness and quality of care is necessary. At the same time, we are aware that right-wing governments, adopting a Thatcherite agenda, will portray cuts that compromise quality care, and ultimately threaten universality, as positive restructuring. Mike Harris and his regime represent that sort of government and we will therefore oppose the cuts for what they are.

One fundamental principle of the MRG recognizes the impact of social and economic forces on health. Cuts in social services and income transfers, a result of both federal and provincial policies, will lead to deteriorating population health. The MRG must work to encourage a public recognition of this situation.

The MRG recognizes that the OMA has repeatedly behaved in an undemocratic manner with respect to dealing with its membership. Moreover, we have long been critical of its active support for user fees and its failure to defend universality. At the same time, the OMA may at times take positions that are consistent with our principles and with the positions we have worked out. In particular, the OMA is likely to oppose health care cuts. When it takes positions consistent with our principles and with the public interest, we should not hesitate to ally ourselves with the OMA.

We oppose solutions to the maldistribution of physicians that selectively penalize new physicians. The proposed restriction on billing numbers is coercive and would be most damaging to newly-graduated doctors. We believe that the best solution would start with adopting a capitation-based system of funding for primary care and salaried positions for secondary and tertiary care that would put new physicians on a level playing field with established physicians.◆

Ontario Health Coalition

The Medical Reform Group joined some thirty other community and labour organizations on December 7th in revitalizing the Ontario Health Coalition to provide leadership on health and health care issues. Coalition priorities for this spring are opposition to all types of user fees and privatization. For more information, contact MRG.

Emmet Hall Dies

Emmet Hall, former chief justice of Saskatchewan and a justice of the Supreme Court of Canada, died November 12th in Saskatoon. Although he distinguished himself in over 50 years service in the courts and tribunals of the land, Hall is best known to generations of Canadians as the father of Medicare.

Hall was appointed by former Prime Minister Diefenbaker in 1961 to head a royal commission on health care. That report, delivered to Parliament in 1964, was the basis of Medicare, based on the premise that "Canada's human resources, men, women, and children, are worth the price that will be paid in taxes in ensuring that all Canadian enjoy the best health possible." He argued that "the only thing more expensive than good health care is no health care."

In his 1980 review of the health care system, he recommended against extra-billing, and provincial medical insurance premiums. Both of those recommendations were integrated into the Canada Health Act, passed in 1984.

In one of his last public statements, Hall took issue during the 1993 federal election with remarks of Reform Party Leader Preston Manning on user fees, which he saw as a recipe for disaster. He added, "There are certain provinces which are unable to carry Medicare. They have to have support from Ottawa. If they are left on their own, they wouldn't have the money to carry the program. I'm sure they will find a way to control [the deficit]. Times will get better. It won't be impossible to keep Medicare."◆

Medical Reform Welcomes Letters..

December 13, 1995.

Dear MRG Members,

I was very sorry to have missed the MRG meeting on November 18, but life with a toddler still keeps me close to home. I am keen to get back involved with the MRG and appreciated Gord's kind invitation. It seems an important time for the MRG to have a focus and a voice.

Areas I am concerned about include:

1. The federal block payments: both the reduction in dollars for health, social services and education (which is overwhelming in itself) but also the reduced ability of the federal government to set national standards in all three areas and the tendency for provinces to fall to the lowest common denominator.

2. The Harris government's push on privatization of health/social services. I've heard that Ministry of Health and MCSS people are talking of reducing human resources in service agencies through 'purchase of service contracts' tendering for the lowest bid. This will create a temporary low-skilled workforce with no stability and will I believe negatively affect quality of care.

3. The lack of a system for primary health care in the province. If we believe that primary health care is not just first care but most important then we need a system to ensure it is not the patchwork informal network we have currently. When we consider how well funded the tertiary care system is, a small investment in the primary care system (say Dennis Timbrell's severance package?) could go a long way in improving the health of the people of Ontario.

It's nice to be back!
Fran Scott

Doctors Split on Capitation Alternative

The MRG issued the following media release on November 7, 1995

As reported in the Globe and Mail on November 7, Dr. Jack Armstrong, president of the Canadian Medical Association, says Canada's doctors are prepared to fight attempts by government to introduce a population-based funding system. Dr. Armstrong is right that doctors are prepared to fight, but some of them will be fighting for, not against, a new system of reimbursing physicians.

Currently, most of Canada's doctors are reimbursed by fee-for-service: they are paid for each item of service they deliver. In this system, the more visits the patients make, and the more procedures or tests the physician supervises or carries out, the more money the doctor receives. If patients don't make visit the doctor, the doctor makes no money.

In the population-based or capitation system, the doctor is rewarded for helping to keep patients healthy. The physician receives a set amount for each patient in her or his roster, no matter how much, or how little, service they use. 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.

Capitation-based systems have many advantages. First, the incentive to 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 communities' needs. Capitation could positively influence the distribution of physicians, encouraging practice in under-serviced areas.

Capitation has been the basis of the British primary care system for decades, and has worked well. Many doctors participating in an experimental capitation-based plan in Ontario remain enthusiastic, and are defending the plan against possible cuts.

Dr. Armstrong is not presenting a physicians' consensus view of capitation-based funding. The traditional medical associations are shortsighted in their rejection of the new model. The Medical Reform Group calls for an open debate on the merits and problems of capitation-based versus fee-for-service funding within the medical profession.◆

Semi- Annual...

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- assessing the feasibility of day long educational conferences for members and potential members, beginning with physician remuneration and privatization;
- going another step or two in the use of electronic technology, with the launch of a world wide web page early in the new year.

MRG Steering Committee Meetings rotate between Toronto and Hamilton on a monthly basis, and are open to all members. The next meeting is set for Wednesday, January 10th, at the home of Rosana Pellizzari, 39 Lessard Avenue, Toronto (Jane and Bloor Area). If you are interested in attending please contact MRG for an agenda.◆

If you have energy to devote to any of these issues, please contact MRG at (416) 588-9167 [voice]; (416) 782-9054 [fax];or jemaher@web.apc.org [e-mail].

Tax Cuts to Ride on Backs of Poor and Sick

The MRG issued the following media release on November 9, 1995

On November 8, the Globe and Mail reported Ontario government plans to begin to charge user fees for drugs currently provided for free to seniors and people on social assistance. The proposal will penalize Ontario's most vulnerable groups, and will further threaten their health.

The poor and the elderly suffer more health problems than other people. Their health problems add to the burden of suffering already imposed by poverty, and by the threat of infirmity. The Ontario government proposes to add to this burden by imposing financial barriers to receiving the medication these people need.

Medication is an essential part of required health care. The poor and elderly do not ask to be sick, nor do they decide what medication they need. While physicians often oversubscribe medication to the elderly, patients cannot distinguish between the drugs they need and the drugs they don't need. The user fees proposed by the government will mean that the poor and elderly either do without some needs, at times including an adequate diet, or without essential medication.

If the government wishes to save money on drug prescribing, education and monitoring of physicians is the appropriate strategy. The government's proposal will only increase the already widening gap between both the health and the wealth

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"FAIR SHARE" HEALTH CARE

We will ask for one thing...to re-invest some of the income tax savings into our health care system.

A "Fair Share" health care levy will be collected through the provincial income tax, with the rich paying more than the middle-class, and people making less than $50,000 a year paying nothing. At $50,000 the levy will be $100.

It's important to note that the tax savings in the chart on the previous page include the health care levy. The average middle-class family will still save more than $4,000 over three years.

Under this plan, everyone will pay their fair share, and top quality health care will be available to all Ontarians. Specifically targeted for health care and geared to income, **"Fair Share" will generate $400 million in revenues for the health care system.** This will completely offset the $400 million lost by abolishing the payroll tax on small business. (See the "Removing Barriers to Growth" section on page 14.)

For some time now, there has been growing debate over the most effective way to ensure more responsible use of our universal health care system. In the last decade, user fees and co-payments have kept rising and many health care services have been "de-listed" and are no longer covered by OHIP.

We looked at those kinds of options, but decided the most effective and fair method was to give the public and health professionals alike a true and full accounting of the costs of health care, and ask individuals to pay a fair share of those costs, based on income. We believe the new Fair Share Health Care levy, based on the ability to pay, meets the test of fairness and the requirements of the Canada Health Act while protecting the fundamental integrity of our health care system.

Under this plan, there will be NO new user fees.

FAIR SHARE HEALTH CARE LEVY

Taxpayer Income	Levy as % of Income	Annual Levy Cost $
Under $50,000	0.00	$0
$50,000 to $60,000	0.20	$100
$60,000 to $70,000	0.33	$198
$70,000 to $80,000	0.48	$336
$80,000 to $90,000	0.78	$624
$90,000 to $100,000	0.98	$882
$100,000 to $125,000	1.20	$1,200
$125,000 to $150,000	1.58	$1,975
Over $150,000	2.00	$3,000

Note: Cost at lowest income in tax bracket

The Common Sense Revolution

A Warning for Mike Harris

The MRG issued the following media release on November 22, 1995

Mike Harris has been told that, to effectively implement his reactionary revolution, he should emulate Alberta Premier Ralph Klein. Cut fast, deep, and don't stop to think about who is being hurt.

Mike Harris promised not to introduce user fees. He has now proposed user fees for medication for the most vulnerable, the elderly and those on social assistance. Promise broken.

The Premier promised to protect the health care system from further cutbacks. Every indication suggests that, in his upcoming budget statement, he'll break that promise too.

Once again hitting at the most vulnerable, Harris has already implemented his welfare cuts. We anticipate huge cuts in the civil service, with tens of thousands of people joining the ranks of the unemployed. These policies come with tax cuts that benefit the affluent. We know that the greater the gulf between the rich and poor, the worse a nation's health. The Ontario government's policies, which further increase the growing gradient in wealth in our province, will adversely affect health status. The need for health services will, as a result, grow.

Up to now, Harris could look to Alberta for encouragement. He could finance his tax cut by penalizing the poor and elderly, breaking his promises, and cutting health care. After all, Ralph Klein has gotten away with it.

Now, Albertans are finally saying that Klein has gone too far with his health care cuts. About 3,500 hospital workers have gone on a wildcat strike. Alberta's doctors are bitterly opposed to the cuts. The public is demanding that universal health care be protected.

There is a message here for Mike Harris, and for the health workers and people of Ontario. We needn't stand back and watch health and social services be cut. As one physicians group, the MRG is ready to fight health care cuts. We anticipate working with other health worker groups, and with labour and consumer groups, in this campaign.◆

Harris' Budget Disaster for Ontario's Health

The MRG issued the following media release on November 30, 1995

Mike Harris' budget statement sacrifices the health of Ontario citizens for an ideological vision that rewards the privileged, and penalizes the disadvantaged. The consequences of this budget, full of broken promises, will be a deterioration in health for many of us, and in health care for us all.

Before the election, Harris promised no new user fees for health care. The government will now charge user fees for drugs currently provided free to seniors and people on social assistance. These user fees will penalize Ontario's most vulnerable groups, and will further threaten their health.

The poor and the elderly suffer more health problems than other people. Their health problems add to the burden of suffering already imposed by poverty, and by the threat of infirmity. The Ontario government's user fees will add to this burden by imposing financial barriers to receiving the medication these people need. The people who will suffer most are the sickest, those with chronic illnesses like heart failure, diabetes, or chronic lung

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Omnibus Bill a Prelude to US Style Health Care

The MRG issued the following media release on December 8, 1995

The closer you look at the omnibus bill, the more you see the Harris' government's ultimate agenda. One of these agenda items is to destroy universal high quality health care in Ontario.

One item in the omnibus bill implements changes to the Independent Health Facilities Act. This act regulates certain facilities that provide outpatient care, including minor surgical procedures such as cataract operations, and investigations such as endoscopy. Hidden in this bill are changes to sections 5(1), 6(3), 6(4) and 6(5) of the Independent Health Facilities Act. These sections currently direct the Ministry of Health in three important directions when establishing Independent Health Facilities.

First, the Minister of Health must give preference to facilities that are operated by Canadian citizens. Second, non-profit facilities must be given preference. Third, the Minister must solicit proposals for new Independent Health Facilities from the general public.

Under changes in the omnibus bill, the Minister of Health will be able to request proposals from specified person(s) who will be able to operate their facilities in a for-profit manner and who will not be required to be Canadian citizens. These changes allow the Minister of Health to request US health providers set up for-profit clinics in Ontario. This profit to private US health care providers will occur at a time when $1.3 billion is being cut from the health care budget and user fees are being introduced.

What is the motivation for these changes? They are a prelude to privatizing Canadian health care institutions. There can be no other motivation, no other excuse. The government is burying these changes in the omnibus bill so that they will not receive scrutiny or debate.

The Ontario Tories lied about cuts to health care, and they lied about user fees. Now Jim Wilson says that we should trust him not to use the wide ranging powers of the omnibus bill, power far beyond that held by any previous Minister of Health. The changes to the Health Facilities Act is only one of the ominous proposals in the Harris' government's legislation.

The MRG opposes Bill 26 and calls on the government to abandon forthwith this ill-conceived attempt to limit democratic debate.◆

February Issue of Newsletter

The editorial board of the ***Medical Reform is*** reviewing the format of the newsletter. If you have recommendations that would make the newsletter more user friendly please let us know as soon as possible.

The February 1996 issue will have a theme, the privatization of health care. Contributions are invited on disk or by e-mail to jemaher@web.apc.org or mail disks to **MRG** at P. O. Box 40074, 280 Viewmount Avenue, Toronto M6B 4K4

Provincial Restructuring: The Ominous Bill

Bill 26: Limited public hearings have been scheduled in Toronto and centres around Ontario, ending up in Hamilton on Friday, January 19th, 1996, where MRG expects to be presenting a brief. For more information call (416) 325-3519 or fax 325-3505.

Letter sent to Premier Mike Harris

November 17, 1995.
The Honourable Michael D. Harris,
Premier of Ontario,
Room 281, Legislative Building,
Queen's Park,
Toronto, Ontario M7A 1A1

Dear Premier,

The Medical Reform Group was formed in 1979 to act as a voice for socially concerned physicians and medical students in Ontario. We are writing to express our dismay that your government is proposing to make changes in the Ontario Drug Benefit program by implementing user fees and/or co-payments. This will have devastating repercussions on the most vulnerable in society. The Medical Reform Group also views this as a direct attack on universality. The Ontario Drug Benefit Program is a fair and equitable program that enables all residents in Ontario to obtain coverage for necessary prescription drugs and is the key to ensure universality. No one should be denied needed drugs.

By implementing user fees and co-payments we assume you want to control government spending and thereby save money. This is simply not the case. There is no proof that user fees will cut costs. This was evident when Saskatchewan introduced user fees in 1968, the end result was there was no change in health costs. As many governments have since learned, user fees act as a very small source of revenue relative to the cost of operating health care services. User fees restrict accessibility and creates a two tiered health care system - one for those who can afford it and one for those who can't. The most serious problem with user fees is it will penalize the least healthy because it often discourages people from seeking treatment they need. This will lead to greater costs in the long run with an increase in hospitalization cases. Preventive health care is the most effective type of health care.

The myth that user fees deter frivolous use of services is a false assumption. User fees only deter the most vulnerable from getting help they really need. For many, user fees may become a financial barrier. User fees are not an equitable solution.

Instead of targeting the Ontario Drug Benefit program there are several areas your government could reform:

1) Pressure the Federal government to repeal Bill C-91 - the drug patent legislation. This is one of the main causes for increasing drug prices.

2) Save the Ontario taxpayers and treasury millions of dollars by enacting legislation similar to that in British Columbia making it mandatory to prescribe and dispense generic drugs where available, instead of the far more costly brand name drugs.

3) Demand the pharmacists lower their dispensing fees. These fees make prescription drugs too costly.

4) Overuse and misuse of medicine are both costly and unhealthy.

5) As you know, seniors don't prescribe drugs, doctors do. As a result, many drugs prescribed are not needed. We must look at educating seniors and doctors on this issue.

6) Several groups, among them affiliates of the Ontario Coalition of Senior Citizens' Organizations, are already working on programs where seniors train other seniors on the sane use of medication. Your government should encourage such programs across the province. And lastly, look at a different system of payment to physicians.

In closing, user fees are in direct conflict with the principle of universality. User fees will further diminish universal health care in Ontario with the poor and seniors bearing the brunt of your proposed actions.

We call on you to avoid dangerous steps that would destroy the social fabric of health care in our province. We urge you to respond to our concern.

Harris disaster budget...

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disease that require multiple medications.

These medications are an essential part of required health care. The poor and elderly do not ask to be sick, nor do they decide what medication they need. The user fees proposed by the government will mean that these vulnerable groups will do without basic needs, at times including an adequate diet, or without essential medication. Promise broken.

Before the election, Harris promised to spare the health system from his budget slashing. He now plans to cut 1.3 billion dollars from hospital budgets over the next three years. Hospitals are already walking a tight-rope, having endured major cuts in the last five years. The new cuts will seriously compromise care, and will propel us down a disastrous road. The people of Alberta have already been led down that road, and only now are they drawing back, having seen how large cuts to a beleaguered system can compromise health care. Mike Harris is ready to dismantle a health care system that is among the world's best. Promise broken.

Health is dependent on more than health care. Poverty and despair compromise health, and the worse the poverty and despair, the greater the deterioration in health. Harris' huge cuts to social services will further widen the already growing gap between rich and poor. We know that the greater that gap, the worse will be the health of a nation's citizens. Harris social service cuts will put further pressure on a health care system that will no longer have the capacity to adequately respond.

Is this sacrifice of health and health care necessary? The magnitude of the cuts is required so that Harris can fulfill another campaign promise, tax cuts. Harris is ready to break promises and penalize the vulnerable, while insisting on keeping promises that benefit the privileged. Sacrificing our health care system on the altar of tax cuts is immoral.

Alberta has shown us that even the most ideologically fanatical government must retreat when a province's citizens finally say no. The MRG is ready to work along side other health workers, consumer groups, and the general public to stop this budget, and the possible destruction of our health care system that goes with it.◆

Letter sent to Calgary Laundry Workers

November 23, 1995.

Canadian Union of
Public Employees,
Local 8, Laundry Workers
203 - 7A Street, NE,
Calgary, Alberta
T2E 4E7

Dear Friends of Medicare,

The Medical Reform Group is an Ontario-based group of physicians and medical students committed to the maintenance of high-quality, universally accessible health care.

As physicians we are very concerned about the impact that savage cuts have on the ability of the Canadian Government to live up its obligations under the Canada Health Act to the Canadian people. Furthermore, as physicians we are alarmed at the inroads that private industry is making across the country into health care.

Health care is a right and is not a privilege to be paid for by those who can afford it.

We therefore applaud and congratulate you on the courageous signal you have sent the Canadian people. Although Alberta has been bearing the brunt for the past few years, this is an issue of major concern to ALL Canadian people across the whole country.

MDs, patients differ on health views.

Survey shows doctors see medical system through 'tint of self-interest,' expert says

by Jane Coutts
Health Policy Reporter

Toronto

One-fifth of Canadian doctors would prefer to go south for medical care if they were seriously ill, a new survey has found.

That is almost three times the number of health-care consumers who would prefer to be treated in the United States if they had a serious illness or injury -- and just one of several differences doctors and patients show in their attitudes toward the health-care system.

The survey, the fourth annual study of doctors' opinions by The Medical Post, showed that Canada's physicians have some serious doubts about the country's health-care system. More often than not, their view is more bleak than that of the patients they serve.

Of the 1,710 physicians surveyed, only 6 per cent agreed with the statement "Canada's health-care system is excellent," while 19 per cent of consumers did.

Doctors were also more pessimistic about the future, with 76 per cent predicting the health system will get worse over the next 10 years. But the opinion survey of 1,500 consumers, done in tandem with the doctors' survey, showed that just 58 per cent of them thought the system will deteriorate over the next 10 years.

The two surveys were conducted differently. The one for doctors was mailed out to 8,400 doctors, of whom 1,710 responded; the survey of patients was done by the Angus Reid polling firm.

As other surveys found, a much higher number of doctors favoured a two-tiered system of medicine, than do members of the public (41 per cent).

And where 56 per cent of doctors said Canada would be better off if Medicare had never been introduced and only private insurance allowed, only 36 per cent of the public agreed.

Dr. Gordon Guyatt, of the Medical Reform Group, said in an interview than the results reflect the fact that physicians "tend to see the medical system through the tint of self-interest... If you believe that health care is better if doctors' incomes are higher, then they may be right."

Dr. Guyatt also said that the preference for US care may reflect the fact that people with high incomes, such as doctors, can get care faster in the United States.

Indeed, the survey showed that Canadian doctors are for the most part quite satisfied with the care they get at home. Sixty-nine per cent of doctors questioned were very or extremely satisfied with the time their doctor spent with hem, and 76 per cent of physicians were very or extremely satisfied with the way their doctor answered their questions.

Doctors are less pleased with the health care they offer, however--62 per cent agreed "government policies unreasonably restrict my ability to practice the kind of medicine best for my patients."

Nor did the doctors think practice standards with government-dictated protocols would improve overall quality of care: 80 per cent of those surveyed thought they would decrease physician satisfaction with their work.

However, slightly more than half the doctors thought "government-imposed practice standards involving protocols

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PROTECTING PRIORITY SERVICES

Let's start with the top priorities – the essential services that Ontarians want to see protected...

■ HEALTH CARE

We will not cut health care spending. *It's far too important.* And frankly, as we all get older, we are going to need it more and more.

Under this plan, health care spending will be guaranteed. **As government, we will be aggressive about rooting out waste, abuse, health card fraud, mis-management and duplication.**

Every dollar we save by cutting overhead or by bringing in the best new management techniques and thinking, will be *reinvested* in health care to improve services to patients. We call this common sense approach, "patient-based budgeting".

Patient-based budgeting means that we put the priority on the people who need health care. It means that the focus is on how we can put more of our health care dollars into direct care for those in need, and more into the preventive care, which can help people avoid becoming ill in the first place.

For many who need care, this should mean an end to rationing and waiting lists. The fact that cancer patients can be trapped on waiting lists for months is a crime. The fact that pregnant women can't get epidurals is a scandal. The fact that people needing kidney dialysis have to wait in line is unacceptable.

For the professionals within our health care system, this means freedom to find more efficient ways of spending without worrying that the government will siphon their savings off into other programs.

The Common Sense Revolution

Hospitals preferred over tax relief:

OHA plans to show survey findings to Tory government bent on restraint

Michael Grange

Toronto-Ontario residents would rather give up tax cuts than see financing cuts to hospitals, according to a province-wide survey released yesterday.

The preliminary findings were part of an Environics poll being conducted on behalf of the Ontario Hospital Association to determine public attitudes toward the quality of care in the province's 291 public hospitals.

OHA chairman Bob Muir said yesterday the findings will be presented to the Conservative government as it considers potential across-the-board cuts in hospital funding.

"The OHA has heard what the government has to say about fiscal restraint. And we have heard from the public," Mr. Muir told a news conference before the opening of the OHA's annual meeting.

Some of the preliminary results of the survey include:

Seventy-five per cent expressed satisfaction with the quality of care provided by the province's hospitals and the same proportion said they opposed cuts to health care in general.

Nine out of 10 said the level of spending on hospitals should be maintained or increased. Only 10 per cent of respondents said it should be reduced.

When asked to rank government spending on hospitals as a priority compared with 10 other areas of government responsibility, including education, social spending for the poor and education, respondents said hospital spending should rank first.

Asked how they would reduce hospital

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Tax cuts to ride...

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of our society's haves, and have-nots.

Implementing tax cuts that will benefit the affluent at the expense of basic medical care for the poor and the elderly is immoral. The Harris government should withdraw their proposal to charge the elderly, and those on social assistance, for essential medication.◆

More patient education is urged.

Robin Harvey

To help reduce unnecessary visits to doctors, the provincial health ministry conducted a public education project last year in London, Ont.

Literature pointed out that Ontario doctors see 9.5 million people with colds and flu every year, costing taxpayers $200 million.

If the project had worked, it could have been expanded province-wide.

But according to Paul Kilbertus, spokesperson with the health ministry, the campaign was a flop.

"The effect on patient behavior wasn't what we had hoped for," Kilbertus says. The ministry now believes more direct patient education from a family doctor would be more effective.

People can change the way they use the health-care system, but they need support from health care providers to do so, medical experts say.

Dr. Rosana Pellizzari, a spokesperson for the Medical Reform Group, says three areas must be covered to help effect change.

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Hamilton may be off limits to new doctors

Suzanne Morrison,
Medical and Health Reporter

New doctors will be prevented from hanging their shingles in Hamilton under a proposal by the province, a spokesman for a doctors' group fears.

Dr. Margaret Kruk, representing the Professional Association of Interns and Residents of Ontario, said yesterday she believes the city could be one of 12 targeted by the provincial government as having too many family doctors.

Hamilton is in all likelihood on the list, as are all the major academic health science centres," said Dr. Kruk, a resident in family medicine at McMaster University. "(This means) that starting in July there will be no new family doctors allowed to come into Hamilton at all," she said.

The Ontario government has indicated it could introduce new legislation that would give it wide powers over the medical profession, such as negotiating contracts directly with doctors rather than through the OMA and issuing new billing numbers only to doctors setting up practices in remote, underserviced areas of the province.

"The billing restrictions apply only to family doctors," Dr. Kruk said.

Ministry of health spokesman Paul Kilbertus would neither confirm or deny if Hamilton is on the list. "It possibly could be," he said.

He said the government has told the OMA that it has identified 12 communities that have too many doctors.

Using a ratio developed by the Ontario Council of Faculties of Medicine, Mr. Kilbertus said the government believes the appropriate ratio is one family doctor per 1,380 population.

Although no ratio is available for Hamilton, in central west Ontario, which includes Burlington, that ratio is one to 1,176. Eastern Ontario has the highest ratio of one to 964 doctors, while Toronto is 67 per cent oversupplied with doctors, Mr. Kilbertus said.

Doctors in Eastern Ontario are facing an uncertain future.

Dr. Kruk, now in Thunder Bay as part of McMaster's Northwest Ontario Medical Program, said the university's pioneering training program is

a far better way to attract young doctors to remote northern communities than what the government is proposing.

"Sixty-five per cent of the graduates of the program end up in rural or northern areas," she said.

Forced recruits will simply burn out and leave, she suggested.

In addition to restricting billing numbers to doctors who will agree to practice in the north, Dr. Kruk said the government is also proposing that specialists be affiliated with a hospital before getting a billing number.

This would target pediatricians, psychiatrists, dermatologists and radiologists, she said.

"The government is trying to push them out of office-based practices," she said.

Dr. Gordon Guyatt, a member of the Medical Reform Group and director of the residency training program in internal medicine at McMaster, said the government is being dictatorial and coercive.

"It's not necessary and it's extremely unfortunate that it is going to penalize young physicians," he said.

There are 70 residents in Dr. Guyatt's program and with hospital cutbacks they may have trouble finding a hospital that will give them a billing number, he said.

"It gives them the prospect of zero income," Dr. Guyatt said. "They have a minimum of seven years, and most eight, nine, or 10 years of training. It's potentially pretty awful and it's particularly awful because there are alternative ways of dealing with it."

In a press release issued yesterday, the Medical Reform Group called the government action "union busting."

Better strategies would be changing to a capitation system to reimburse doctors, providing incentives for physicians to go to underserviced areas, special supports, and service paybacks for assistance to medical students, the MRG said.◆

Reprinted courtesy of the Hamilton Spectator, November 28, 1995

More patient education...

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First should come general education, such as the literature from the health ministry pointing out that a visit to the doctor is not necessary for simple colds and flu.

Next strategies have to be in place, to enable patients to change their behavior. This could involve phone contact to discuss symptoms or other strategies to ease concerns, Pellizzari says. Or a nurse practitioner could assist, instead of a doctor.

Finally, the program must be followed up with positive feedback to ensure the change sticks.◆

Reprinted courtesy of the Toronto Star, November 23, 1995

MDs, patients differ...

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of investigation and treatment" would help control costs and ensure a desirable standardization of practice patterns.

While 56 per cent of doctors surveyed disagreed with a statement that increasing the size of a practice is the only way to deal with shrinking fees, they don't see the idea as a new one--70 per cent of the doctors surveyed said somedoctors do bring patients in more often than necessary into order to maintain their incomes. Far more patients (41 per cent) than doctors (19 per cent) believe patients are visiting the doctor less often in an effort to control costs.

In a section of the questionnaire on medical ethics, doctors were split almost equally on the question of whether physicians should be free to help patients commit suicide under some circumstances; only 18 per cent had ever been asked about physician-assisted suicide.◆

Reprinted with permission of the Globe and Mail, November 3, 1995

Critique of Alberta Medical Association Proposal for Fee for Comprehensive Care

by Michael Rachlis

Introduction

The Alberta Medical Association has proposed changing the way some family doctors are paid in their proposal of a 'Fee For Comprehensive Care'. The AMA is now negotiating details of this plan behind closed doors with the provincial government. Versions of this plan, have been in operation for many years in Britain and Ontario. Saskatchewan and British Columbia have just recently begun small-scale experiments with this model which is generally called 'capitation' or literally 'per head' funding. The Staff Nurses Association of Alberta strongly supports developing capitation and other alternatives to fee for service but the SNAA is concerned that the new fee system would simply reinforce doctors' monopoly on the control of health care and not result in better services for patients. The SNAA has outlined its plan in **Community Health Centres: The Better Way to Health Reform**. The SNAA demands that the province involve the public in a discussion on reform to primary health care.

What's wrong with the current fee for service system

Fee for service is literally piece work. Doctors are paid a fixed fee for each specific service. When formal health services developed in Canada, almost all health care was acute care. Doctors, not surprisingly, charged a fee for each episode of care they provided, for example, taking out an appendix or lancing a boil. But today, the nature of health problems is far different. Acute illness has been overtaken by chronic ailments like heart disease, cancer, and mental illnesses.

At the same time, we have learned better ways to deliver health care, for example, the importance of patient communication and health promotion. And, we know that nurses and other health professionals can often deliver services as well or better than doctors, at less cost. Nowadays, almost all health professionals including nurses, social workers and others are paid salaries or wages. And, it has become clearer and clearer that fee-for-service too often increases health care costs and penalizes doctors who want to practice good medicine.

For example, Medicare usually pays doctors the same fee for a particular service regardless of the time or effort involved. A doctor in Alberta receives a range from $17 to $26 for seeing a young healthy person with a cold which could take five or ten minutes and the same dollars for seeing a elderly patient with pneumonia which could take half an hour. Also, under fee-for-service, doctors receive no extra payment for spending more time to explain different treatment options or possible side effects from medication. In general, doctors are paid very well for cutting and prodding but very poorly for listening and thinking. As a result a conscientious family doctor who puts in sixty hours a week takes home less than a plumber who works fifty. At the same time, doctors who are prepared to run 'assembly-line' practices get paid better than the Prime Minister.

Studies of the Sault Ste Marie Group Health Centre,

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Ontario HSO Program: a capitation island in a fee-for service sea

by Bob James

History

The Health Service Organization (HSO) began during the term of the Progressive Conservative government over ten years ago. At that time, there was a lot of talk about alternate ways to deliver health services. It was also during that time that the government began the experiment with Community Health Centres (perhaps in response to the Quebec government's implementation of the CLSCs). But the HSOs were to be physician-sponsored, while the CHCs were to be governed by a community board.

The idea for the HSO was fairly simple and made logical sense: pay a doctor per day, the average amount billed OHIP (for primary care) in his area for someone in the same age-sex category. In return, that doctor would provide all primary care services to that patient. This was called capitation, and was based on the system is use for over thirty years in Britain. If the patient went elsewhere and a bill was generated, the capitation fee attached to that patient would be lost for that month, and would resume the following month.

In addition, there was a plan put into effect to encourage prevention. If a physician's rate of hospitalization were to be below the average of this area, the projected hospital "savings" would be shared, one third to the physician, and two thirds to the government. If the rate of hospitalization were higher than average, there was no penalty.) this was called ACIP (Ambulatory Care Incentive Program), and was to provide moneys for preventive services.

This system worked well from the physician's point of view. There were practice advantages quite quickly. More could be done over the phone, or by nurse-practitioners, since the money earned was not tied any longer to the physician having to see the patient. As long as the patient was happy, the doctor earned his money. As well, there was no longer any limit to the number of exams, complete or otherwise, that a particular patient received. This was between the doctor and the patient. Obviously, if you get a set amount of money, the bias of the system is to do the fewest number of exams which are necessary to keep the patient happy, (and presumably, healthy). And you got away from the feeling that you filled out the OHIP card with only enough information to justify the bill.

As well the financial rewards were noticeable. For many of us, getting paid for all that we had been doing (over the telephone, or in letter form, or whatever) meant a rise of between ten and twenty per cent in our incomes. As well, there was the incentive mentioned above (ACIP). This could easily amount to thousands of dollars a month per physician. And although this money was intended to go for prevention programs, there was no good follow-up on this or good guidance on what would constitute prevention programs. But many or us felt that we were getting adequate payment for our work for the first time since we began practice. Money was not an issue, because there was enough (probably too much).

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Clinic, and the Saskatoon Community Clinic which are not paid on fee for service and employ salaried doctors have demonstrated 15 - 30% lower patient costs than fee for service patients primarily due to a lower rate of hospitalization. These results are supported by a very large American study conducted by the Rand Corporation in the 1980s for the US Health Care Financing Administration. The Rand study compared patients in Seattle, Washington who were cared for by the Group Health Cooperative of Puget Sound (which was not paid on fee-for-service) to patients cared for by Seattle fee-for-service doctors. The fee-for-service patients cost 40% more than the patients cared for by the Group Health Cooperative -- again mainly because of higher use of hospitals.

Payment systems are really incentive systems. Fee-for-service, like piece work, provides an incentive to do more. Other payment methods, like salary, provide an incentive to do less. Most reports on health care note we also have to look at other ways to improve quality of care beyond how we pay doctors -- including more research on what works and better systems of quality assurance. However, the fact remains that fee-for-service appears to increase costs without improving quality of care.

What is capitation payment

Capitation payment is literally 'per head' funding where the doctor or health centre receives a fixed amount of money every month for every regular patient. Instead of submitting a bill for every service provided the doctor or centre would enroll patients by getting them to sign a form registering them at the practice. From that point, the health care provider would receive a certain sum of money to provide all contracted services. Depending upon the details of the capitation plan, the provider could contract just to provide family physicians' services or a package of services including nursing, dietetics, and even laboratory services and some prescription drugs. In Britain family doctors have been paid on capitation for decades and, in 1991, a new policy created 'fundholding' practices where the family doctors also receive an enhanced capitation payment intended to pay for some elective surgical procedures (for example, hysterectomy, gall bladder surgery) as well as a list of common lab tests and prescription drugs. This year some general practices will become 'total fundholders' where they will receive virtually all the funding for health care for their enrolled patients. The practices will have to pay for those services (for example: hospitals, medical specialists) which they don't provide themselves.

Capitation is seen as providing more appropriate incentives for health providers by changing the focus from short-term care for episodic problems to long-term management of the overall patient and his or her family. However, capitation can also provide an incentive to simply underservice people and to 'dump' really sick patients who need a lot of care. That is why it is crucial that the details are done right or else capitation could simply lead to different problems than fee for service.

Ontario has had over twenty years of experience with a capitation model for primary care -- the Health Service Organization or HSO program. There are over 90 centres involving over 400 family doctors. The HSO program includes the innovative, Sault Ste Marie Group Health Association Clinic which has 35,000 patients and is run by a community board but most HSOs are small group medical prac-

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Ontario HSO program...

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The 1993 Contract

Most of this changed in 1992-3, when a new contract was "negotiated" with the Ministry. In fact Michael Decter, then Assistant Deputy Minister of Health, wrote to all the HSOs, canceling all of their previous contracts, and forcing us into negotiations, through the Ontario Medical Association. This was done, and we now have a contract between the Ministry of Health and the OMA, with each individual HSO signing a separate, individual contract an well as the general one with the OMA.

The provisions of the contract were a bit of a shock to a lot of us. There would be no new HSO's, and no new physicians added to existing HSOs. The capitation rate was cut back to 1989 levels (it has since risen a bit). The amount of money billed to us for patient care received by our patients outside the HSO has risen from one month's capitation (a small penalty) to 50% of the amount billed OHIP. We lost ACIP, and have instead program-based funding. Our practice population is capped (they allow 5% growth), and the amount we are able to bill through fee for service is also capped. We (that is, the HSO) are to be available for a minimum of 40 hours per week and have 24-hour, 365 day on-call coverage with other physicians (not PSR-type services). The Ministry was determined to achieve accountability. They have looked into and monitored to make sure that the HSOs are following the guidelines. There is an on-going committee to look into concerns between the HSO and the Government

Many people have left the HSOs and have gone back to fee for service. The gross incomes of the rest of us have dropped in the order of 25%. The system is no longer rich. Many HSO physicians are considering a return to fee-for service, which, though not as appealing on ethical grounds, is better-paying--and less regulated. And perhaps more importantly, we have lost what appeared initially to be a partnership between the Government and the HSO in the pursuit of better health care for our patients.

Present and Future

The HSO group continues to have an advantage over fee-for-service physicians in having access to two good programs begun since the 1993 contract.

The first of these is the Mental Health Program. This was begun to fill an obvious need in the health care of the patients in our practice: counseling and diagnosis/management of mental illness. We now have a program which pays for our social worker, and provides back-up psychiatric consultation (with some provision for child or geriatric psychiatry). Our needs are assessed, based on our population, and the number of hours paid for are assigned accordingly.

The second program also grew out of a need recognized by the HSOs: nutritional support. We now have a dietitian who can come to our office to see our patients, again with the number of hours based on the population. Our patients with Diabetes, hyperlipidemias, feeding problems, etc., can now be managed more in our office settings.

These two programs make up for a lot of what seemed to be taken away from us. Most of us are interested in providing good quality care for our patients in the setting of our offices. The money is important, but not the only thing we are after.

But I think we also need to look at what the program is not doing yet, and could be. For instance, of all the medical delivery systems in Ontario, the

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Critique of Alberta...

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are small group medical practices run by doctors. Unfortunately the program was so badly managed that it has been in limbo for four years. This should be a cautionary tale for Alberta -- capitation plans have to be well-thought out and developed by public discussion, not backroom deals.

The Ontario HSO program didn't have appropriate rules for creating or managing a patient roster. Some doctors registered patients who weren't really theirs and some patients were long dead but the province still paid for their care. Another problem was that HSO doctors could bill fee for service for so-called 'transient' patients. But this supplied an incentive for doctors to roster healthy people who they never saw and bill fee-for-service for sick patients whom they labeled as transients. The HSOs were paid based upon provincial average payments for various age and gender groups (for example, females 0-4 years of age, males 55-59, etc.) but the HSO patients were healthier than average. The HSOs were supposed to hire other professionals like nurses and provide better preventive services but studies showed that they didn't. By and large, the HSO doctors just kept the extra revenue as personal income with some family doctors making more than half a million dollars. And, finally the HSOs were given bonuses if they reduced hospital use by their patients but a study showed that there was no difference in their patients' hospital utilization after they converted from fee for service.

What's wrong with the AMA proposal for capitation payment

First, the province needs to establish a base for primary health care by establishing a network of publicly-controlled community health centres where existing community health services (home care, public health, mental health, etc.) are integrated with salaried doctors. This model is outlined in the Staff Nurses' Association of Alberta document **Community Health Centres: The Better Way to Health Reform**.

Like in Quebec every community of a certain size should have a community health centre to integrate and coordinate community health services, to provide routine primary health care to those who prefer this model and to provide a source of care 'of last resort' for those especially vulnerable people (patients with chronic mental illness and the homeless) who fall thought the cracks of the existing system into hospital emergency departments. Like in Quebec this model would likely be the only source of care in remote areas of the province which did not have the population for competition between different centres. However, in most areas of the province, the community health centres while receiving funding for mandated population-based services (for example, public health) would compete with other primary care centres for individual patients.

Then the province should establish a capitation program which also allows non-physicians to own and manage the new centres. Alberta should not reinforce the existing monopoly that doctors have over health services. Alberta's regions, the Ministry of Health, the AMA, and other groups including consumers need to publicly explore the potential of these new funding arrangements in greater depth before proceeding. The refinements suggested below could make all the difference between success and failure.

How to make competitive, capitation-funded primary care work

The centres should be non-profit

We think that it is crucial all primary care centres

sis. Otherwise, there is simply too much temptation to skimp on care and keep the funding as personal income. Similarly, it is important to set salary ranges for all staff, including doctors. Otherwise, the owners would be tempted to pocket money that should go into patient care. That is, in fact, what happened in Ontario's HSOs. Some of the doctors dramatically increased their take-home pay (to more than $500,000) without improving services to patients. A better arrangement would have policies stipulating how surpluses can be used, allowing perhaps 5 to 10 percent to provide bonuses tied to performance. However, in general, surpluses should be used to improve patient services, not the incomes of providers. For example, surpluses could be used to add dental care to the mix of services provided by a primary care centre.

The province licenses groups which wish to start primary care centres

We think that the province should move to license primary care groups, not just health professionals. Any group which meets the following conditions should be able to get a license to establish a primary care centre:

- A demonstrated ability to provide directly or pay for a full range of services (see next section for details).
- A clear strategy for meeting the province's goals for the health care system. Alberta is exploring the development of performance indicators for health care and other government-funded services. These indicators should focus on health outcomes, like complication rates for diabetics, and they should be published on an annual basis by the Provincial Health Council.
- A willingness to abide by the standards set by collective agreements in force under the Alberta Labour Relations Code. these standards would set ranges of wages and benefits for all professionals and other employees in accord with negotiated agreements for unionized workers. In the spirit of fair play, the primary care centres should compete on the basis of innovative services and the most efficient mix of caregivers, not by cutting wages and benefits.

These criteria still allow for a tremendous diversity of models and enhanced consumer choice. It is quite clear family doctors working in group practice will have a "leg up" on other potential sponsors because they already have practices. Certainly, many family doctors could form very effective primary care organizations. However, rules like these would also allow for a group of nurses, social workers, and physiotherapists to obtain a primary care license, as long as they could show they had contracts with doctors and other essential service providers. Similarly, a group of consumers could also qualify for a license, providing they meet the criteria. To level the playing field, however, some non-physician groups (for example, consumer groups) will need access to resources for feasibility and start up costs. Opening up the primary care arena in this manner should stimulate tremendous creativity and vastly expand the choices available to consumers.

The good news is that allowing all this diversity won't add to costs. After all, getting a primary care centre license is not synonymous with getting public funding. Each centre has to attract patients before it gets paid anything. If the centre doesn't have patients, then it goes out of business -- no need for any planning exercises or political processes.

It is possible to develop a competitive system for primary care within our public-funded health care system. Is the AMA afraid of a little competition? Why would a government which

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Southern Exposure: Managing Patients in a Managed Care Environment

Clifford J. Rosen MD, Chief of Medicine, St. Joseph Hospital, Bangor ME, USA

Absent the Clinton initiative to reform the public-private health care system in the United States, market forces have wrestled absolute control of medical delivery from both the feds and the states. Combined with impending Medicare 'reform', managed care has led to a firestorm of competition among insurers for those valued 'lives' that actuarians (and CEOs) crave. Not unlike other successful enterprises, corporations have already co-opted their previous nemesis, (i.e. health care providers) to join the ride. This has allowed managed care to surge across the country with little or no opposition. In fact, the recent coupling of the Republican plan for Medicare reform (which encourages elders to seek private health plans rather than Medicare) with the American Medical Association's pseudo-agenda for change, has defined just how far and how fast: one group of providers has fallen. With this blitzkrieg of managed care, it is a small wonder that physicians and consumers have been able to survive, let alone speak out about the dire consequences of a new health care system in the United States.

In order to understand this siege, it is necessary to explain the so-called Republican 'revolution'. Their new budget plan includes slashing nearly 280 billion dollars in Medicare funding during the remaining years of this decade. Besides reducing benefits to all seniors, the Republicans have also altered the framework of a three-decade old system which has provided 'free' and unlimited hospital care to Americans over age 65. That program, although not perfect, has been run with an administrative overhead of 2-3% and has succeeded in dropping all barriers to hospital and outpatient care.

Still, most elders do not get their prescriptions paid through the Medicare, and a companion plan makes elders pay a monthly premium of $100-200 for outpatient care (sometimes along with co-payments). Although the United States has no long term care plan, elders can, by 'spending down', qualify for "Medicaid", the state-federal partnership which pays for health care to the poor and disabled. Medicaid enrollment virtually guarantees access to long-term care facilities as well as some home health services.

The new Republican plan removes eligibility for Medicaid and provides health care vouchers to seniors. The vouchers are appropriated to the states in terms of 'block grants' which allow local government to spend those dollars on anything or everything from health care to hospital construction. For the consumer a specific amount of money is allotted to purchase the health care plan he/she desires. However, not all insurers will permit purchasing of a prepaid plan at the price assigned by the Federal government. Thus an 85 year old with chronic renal insufficiency, diabetes and hypertension may not be able to enter the marketplace with an assigned voucher because of pre-existing conditions. In that case, the only option is to return to Medicare, but this time

in a new 'lean and mean' system. Private insurers win because they can pick and choose patients. For-profit physicians win because the Republican-AMA deal insures doctors the same fee schedules as before institution of the reform plan. Ah but the lowly elder loses on several counts:

- the insurance plan may decide not to take the risk of covering such a chronically ill patient (too many illnesses in somebody is not good business!), thereby leaving the patient with a barebones plan;
- the physician will balance bill (illegal under Medicare where a fixed reimbursement fee was instituted);and
- several previously covered health care services would be eliminated.

All this, of course, is in the name of 'marketplace' reform. But, if that were not enough, the Republicans have done more. Medicare's ban on self-referral by physicians, certification of laboratories by the Feds, and Corporate restrictions on billing practices, would all vanish. To sweeten the pot, limits on medical malpractice cases would be instituted and pharmaceutical companies doing phase III FDA trials could legally bill Medicare for administering care to seniors involved in their studies.

In sum, the majority of employed Americans are either now in managed care plans or are moving rapidly towards HMO, PPO or MSO enrollment. (Forget the abbreviations, there is a new one nearly every day; they mean conglomerations of providers and insurers.) But so are the 50 million plus elders in the United States. If one were to believe the ruling party, this process represents a panacea for the US (as well as providing continued tax cuts for the rich).

How does this new 'medicine' affect the physician and the physician-patient relationship? Well, if the provider was fiscally outside the system, he/she could easily become an advocate for the patient. But, besides the push forconsumer participation, physicians have also been subject to tremendous pressure from health care corporations to join the team. Basically, providers are being blackmailed into becoming part owners of managed care networks. These mega-conglomerates, run by private insurance companies (and/or hospitals), have pushed physician independence to the brink. Not only are doctors told to provide inexpensive care to their customers, but they are encouraged to invest in the company. In return, the provider is given a specific amount of money to care for his/her enrolled patients and a guarantee not to be run out of business (very reminiscent of other blackmail prototypes in American history). At the end of one year, if all the patient money appropriated to a physician has not been spent, the provider receives that money plus a bonus from the corporation for not referring or ordering expensive tests. Worse, though, are the financial incentives of partnership which allow the provider to reap even larger economic benefits from the corporation independent of his/her case load. The more successful the business, the greater the revenues for the individual stockholder (in this case the physician). These capitalistic approaches have paid huge dividends for conglomerate as well as participating physicians. The CEOs of these networks command salaries far into 7 figures. The physician, on the other hand, maintains his revenue, retains a certain degree of power and is guaranteed a job.

In the day-to day care of patients, the provider's guide to patient management comes not from national standards but from the company's book of preferred drugs and therapies. Referral is always the last step, and often to subspecialty enrollees who may not be the choice of the primary care pro-

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Ontario HSO program...

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HSO system is the only one which has good statistics, based on its defined population. We know who is and is not in our practice - we need to, since our pay is determined this way. And we collect data with each visit (encounter) which are sent in to the government monthly. This information sits in a warehouse, and has not been analyzed since the inception of the HSO program.

The government made a commitment in the last contract to work on ways to help with disease prevention. This has not happened. And they agreed in the last contract to help us with those people who go elsewhere --first to identify them, then to set up programs to convince them to not do it. They also have agreed to look at how to tease out true emergencies from the others, in patients who went elsewhere for primary care (for instance to the Emergency Departments). Again, this has not happened. There is a lot of room for co-operation and support between us which is not yet happening.

And of some concern in the current economic climate is that there has been no move to open negotiations with us on a contract which is set to a expire next April. In fact the opposite is true. The government has stated that they do not want to talk about anything in committee which involves money (sic). They say that we should not de-roster people if they are frequent abusers of the health care system, claiming that this is discriminatory on our part. And they deny us information on where our patients are going, saying that this is against the confidentiality of information provisions in the Health Care Act. We feel that we are faced with paying for our patients' care when they go elsewhere, when we don't have any way of knowing where they are going, and have no control in where they go. This seems unfair to us.

Many of us are worried. The Deputy Ministers of Health, when they met in Victoria in the fall, felt that the capitation system was the best one for delivering health care. In Ontario, we have the only such program in Canada at present, and it has a history going back more than ten years. And yet the Ministry appears to be strangling it slowly. There have been no new HSOs since 1992, when the review process began (this is the only area of the Ministry's work with physicians that has not expanded --in fact it has shrunk). And those that remain are working harder than ever, for less money than in years, to provide the care that they have contracted to provide.

The Medical Reform Group decided some time ago that a system of capitation was a good way in which to provide primary care. In writing this article, I hope to inform the membership of where the program is now. Your support, both individually and as an organization, may be necessary top the HSOs to continue to exist into the future.◆

Hospitals preferred over...

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spending if required to do so, only 10 per cent favoured a program of hospital closings or mergers. Eighty per cent said their local area has the correct number of hospitals.

Of the 25 per cent of respondents who favoured reduced health-care spending, one-third of them favoured controlling the amount physicians can bill the province's health-insurance plan, while another 25 per cent suggested tightening eligibility for subsidized drugs.

The preliminary findings are based on a random sampling from 800 telephone interviews conducted since Oct. 27. The final results, based on more than 1,000 such interviews, are expected to be released later this month.

continued next page

Hospitals preferred over...

The most surprising finding so far, said Environics spokewoman Jane Armstrong, is the willingness of Ontarians to forgo potential tax cuts to avoid deeper cuts to hospital funding. "I find it very interesting than in an era of tax fatigue, there is a willingness to accept smaller tax savings in order to maintain hospitals," she said.

Gordon Guyatt, a spokesman for the Medical Reform Group, an Ontario based coalition of doctors committed to preserving Medicare, said yesterday the survey's findings were not surprising. "The findings are consistent with every survey of this type I've seen across the country."

"For about the past decade, Canadians have faced the prospect of politicians backing away from universal health care because it's too expensive, and each time the public reaction is so strong they have to back off," Dr. Guyatt said. "It's encouraging to see the will for universal health care hasn't been destroyed among the public."

Mr. Muir, the OHA's chairman, outlined key messages he hoped to deliver to the provincial government before an economic statement by Finance Minister Ernie Eves scheduled for later this month.

While defending the record of hospitals in improving efficiency in he past five years, Mr. Muir said the next step in hospital restructuring would involve institutional mergers, alliances, rationalization of service and closings.

But he stressed that quality and access to care would be threatened if these steps were taken without expanding community-based services. "The government must recognize that there are costs associated with restructuring," Mr. Muir said.

He also emphasized that a substantial reduction in transfer payments would lead to service reduction if implemented across the board. "Large scale, across-the board cuts would have a significant impact on a hospital's ability to deliver service," Mr. Muir said.

"A 10 per cent cut across the board would leave a hospital open from Sault Ste. Marie to Thunder Bay. A 20 per cent cut would mean than my hospital (in Kenora) would cease to be a hospital at all."◆

Reprinted with permission of the Globe and Mail, November 6, 1995

Dial a Doctor: Dialing For Dollars

by Rosana Pellizzari

One has to wonder about the well-being or New Brunswick's Family Doctors: in the words of a popular folk song, "where have they gone?" There seems to be a void, a big black hole, each day, which opens up right at the end of banking hours. Why else would people living in New Brunswick choose to pay $3.99 per minute to "Dial a Doctor" to ask a stranger for health advice? one has to assume that their Family Doctor is unavailable - and that is worrisome.

Of course, there are some entrepreneurs who will say, "If the consumer wants to dial a psychic, or dial a sex-talk line, then why can't he/she also dial a doctor?" There are aspects of health care which can be made into a commodity just like any other product for sale. But, if this Dial a Doctor is just a consumer frill, like fortune-telling or sex-play, then why is it being targeted for evening hours? And why have its proprietor-physicians marketed it as a way to potentially save on

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Critique of Alberta...

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would a government which claims it believes in consumer choice reinforce the existing health care monopoly?

The capitation payments are adjusted to reflect the needs of individual patients

This point is crucial because if the payments aren't adjusted for individual patients then capitated centres will have a strong incentive to dump' patients who require a lot of care. there are anecdotal reports of patient 'dumping' from Britain. The payment should be adjusted for not only the patient's age and sex but also any chronic illness and key socio-demographic factors which would increase the needs for care (for example, being a single parent or a widow).

Patients should be free to change primary care centres at any time

The AMA proposal would 'lock' patients into a practice for three months. It is unnecessary to be so restrictive. Patients should be free to change at any time by signing a form at their new primary care centre. From that day onwards, their capitation payment should go to their new primary care centre.

Capitation plans have to be region-wide

Capitation payments are like insurance premiums and are based on some sort of average need for care. However, it is impossible to compute an actuarially sound capitation rate without including all persons within a particular geographic are. Otherwise the capitation practices have an incentive to 'cream-skim' by picking healthier patients.

Conclusion

It is refreshing that the AMA now is prepared to discuss options to fee for service. But, Albertans should demand that this debate be out in the open. And, the Alberta government should not simply reinforce the existing monopoly doctors have in health care.◆

Dial a Doctor...

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unnecessary emergency room visits?

Hopefully, there will be heard a deafening cry of outrage across this country as Provincial Medical Associations and Family Physicians denounce this walk-in clinic without walls as a bad idea for patients. Dial a Doctor can not be seen as a solution to the inadequate on-call coverage being provided by some doctors. Doctors who have taken the time and trouble to provide good after hour coverage for their patients should voice their disgust with this sorry substitution. Consumers should boycott the service as an expensive, unnecessary and inadequate replacement for a Family Doctor who should be accessible for emergencies, And politicians should see this for what it truly is: an affront to the spirit of the Canada Health Act which makes user fees for medically necessary services illegal.

Perhaps the real problem is that we've all been stupefied by too many years of a "Fee For Service" system which has created a culture of itemization having, as its reference point, the "Fee Schedule": continuity of care has long ago succumbed to individual billable services delivered by the most lucrative physician outlet. And patients have been socialized, in this culture we've created, to viewing their primary care as episodic illness care to be handled by the most convenient provider. This fragmentation can't possibly be good for patients. It certainly isn't good primary care.

Dial a Doctor is one more reminder of how badly we need real reform of primary care in this country. Patients need 24-hour access to appropriate care. In Quebec, the

CLSCs (community health centres) have used telephone technology, nurses, emergency protocols, and access to on-call physicians to provide every community with 24 hour coverage. Provincial Ministries of Health could make the provision of 24 hour care a prerequisite for the licensing or funding of primary care practices. It may be that the Family Doctor's not answering the phone in New Brunswick will serve as a wake-up call for the rest of us.◆

Resources

In response to Ian Scott's review of Linda McQuaig's Shooting the Hippo and the reprint on block funding in the last issue of Medical Reform, several members wrote or called, asking about other readable resources on the financing and delivery of social programs. The following compilation is an attempt to identify a range of current resources and sponsoring groups.

Action Guide From NAPO is a tabloid produced for public education by the National Anti-Poverty Organization, 316-256 Edward Avenue, Ottawa, Ontario. Telephone: (613) 789-0096 or 1-800-810-1076.

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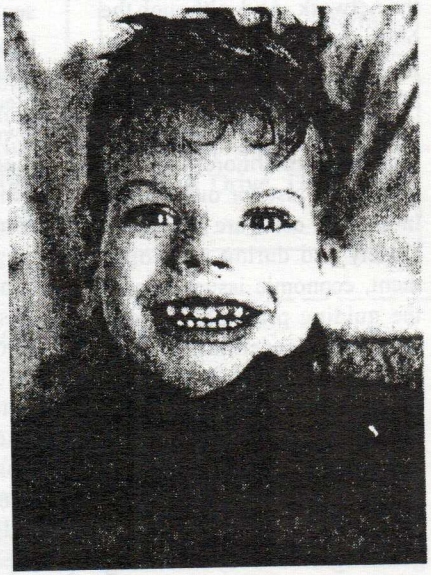
Jake's Life- A Film by Laura Sky

Distributed by Sky Works Charitable Foundation



Jake's Life a new film by Laura Sky, features the battle waged by Jake's parents to secure and defend the health care services necessary to their son's survival; a battle that grows more desperate in face of governments' grim determination to eliminate many of those vital public services. Miriam and Jim are parents and activists. They are outspoken in their effort to ensure that all children like Jake, and other families, receive the care and support they need. They believe that all families deserve access to publicly funded medical services and related supports.

Jake's Life vividly captures Miriam and Jim's fight with an inflexible health bureaucracy - as well as a tremendous practical and emotional upheaval integral to the structure. But Jake's story is a also a positive and encouraging one. Susie's Place shows us that excellent care can be affordable and publicly funded. The film shows us the wonderful collaboration between the child care staff and Jake's family as they all strive to give Jake the best life that he can have.

These are encouraging signs of renewed community attention and advocacy around these urgent issues. ***Jake's Life*** is meant to contribute to those campaigns to ensure that kids and families get the care and support they need and deserve.

VHS video cassette sale price for Institutions and Organizations: $125. Group and individual screenings available upon request. *Contact Sky Works Charitable Foundation, 566 Palmerston Avenue, Toronto M6G 2P7 (416) 536-6581 or fax at (416) 536-7728 for more details.*◆

Southern exposure...

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vider or the patient. In the end, the bottom line remains cost to the network. And, although the physician is guaranteed a job, the overriding consideration at all steps in the process remains how the provider doles out resources. Furthermore, this system is not just for outpatients. In-hospital costs are monitored closely and during reappointment, economic issues remain the guiding principle towards continued credentialling. Rewards come from not spending money, rather than intellectual and scholastic efforts.

How does this translate on the patient level? Very tight commercial regulations have gotten tighter thereby shortening hospital days. This improves the network profile in the eyes of future competitors and partners. But shorter lengths of stay also mean more home care, some portions of which are not covered by insurers. Often this means sending sick patients home before they are ready. A good example is what I witnessed a couple of weeks ago. A wonderful patient with a repaired aortic aneurysm was having continued back pain for more than 5 months. Initially the diagnosis was Paget's disease but after an extensive workup a subacute leak at the suture line of the aneurysm repair was found. The patient was scheduled for elective surgery on Monday. But instead of holding the patient for two days during the weekend prior to surgery on Monday the patient was quickly sent home to return on the very day of his operation (Monday). Well, he didn't quite make it; he bled from his aneurysm at home seven hours after discharge and died three weeks after emergency surgery. My pride as a consultant in making an obscure diagnosis and in helping my patient after months of frustration was quickly vaporized by the absurdity of the situation.

But it was rapidly matched by my anger over another case of a very seriously ill woman with severe osteoporosis, non-tropical sprue and osteomyelitis of the spine. A phone call from an unnamed managed care person during her hospitalization (Yes, they do call the patient's room directly) warned her of impending loss of insurance prior to surgery because she was not sick enough to be in the hospital. Needless to say, this phone call alone caused tremendous anxiety for all involved. After threatening the company with widespread publicity, the wolves retreated even if only for awhile. However, the taste lingered through the rest of the hospitalization, and still remains a sore point for the patient.

These awful stories occur everyday south of your border. Although I think it may be too late for us, it certainly provides a wake-up call to Canadians. **Marketplace health care is for the birds!!** It has stripped physicians of autonomy, reinforced the importance of the almighty dollar, and severely restricted consumer choice.

Moreover, the virtual handover of Medicare to the private sector by Republicans, will make the latter stages of a senior's life miserable. If we are to 'manage' in the managed care of the US we need to remain vigilant and aggressive, unwilling to allow others with little interest in patient care and lots of interest in the dollar, to take absolute control. The first step in this organized opposition has begun at the White House, where Bill Clinton has remained steadfast. Moreover, popular opinion has begun to swing away from the Republicans, leaving some hope of at least maintaining the status quo. Still it is a far cry from the heady days of two or three years ago, when universal health care seemed to be within reach.

Where reformers like myself went wrong, still remains to be determined. However, it is a lesson that is destined to be repeated elsewhere. In fact, I am sure this southern exposure is a preview of conservative directions in your country. Hopefully, this essay will aid your own struggles and provide some insight into the politics of health care, American style.◆

Ontario Social Justice Coalition

Following a recommendation at the November 18th semi-annual meeting, the Medical Reform Group also joined the Ontario Social Justice Coalition, a network of community a labour groups coordinating action on social justice issues. The OCSJ boasts local networks in over 40 towns and cities across Ontario, and has developed ***Bad Medicine***, a traveling educational package, for use in stimulating grassroots discussion around alternative economic and social policy. For more information, contact MRG or Catherine Goulet at the Coalition office (416) 441-3714 [voice], or (416) 441-4073 [fax].◆

The OSJC publishes annually Unfair Shares: Corporations and Taxation in Canada. This thin volume consists almost entirely of data on taxes, tax deferrals, and tax subsidies to corporations operating in Canada. For copies, contact the OCSJ at Suite 305, 15 Gervais Drive, Don Mills, Ontario

I would like to become a member of the Medical Reform Group

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Please return to:
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280 Viewmount Avenue,
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All categories of membership include a subscription to the MRG newsletter **Medical Reform.**
* Members joining for the first time may pay only half the annual fee in these categories. Physicians in other provinces may become Affiliate members. Non-physicians may become Associates.

Condition Critical...

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Health Minister has chosen to take a relatively hard line with respect to violations of the Canada Health Act -- most notably, those of the Klein government in Alberta, which has moved aggressively toward two-tiered care. Whatever Ms. Marleau's political convictions (Monique Begin, who is responsible for the Canada Health Act, was clearly a true believer), the government has sanctioned her approach because of the political mileage they believe will come their way. There is now even talk that the social transfers for health will be kept separate so that the Liberals can take credit for future maintenance of health funding.

There is likely less ambivalence at the provincial level. The Harris government is filled with thinly-disguised Reformists, and their underlying agenda is privatization. Changes in the Independent Health Facilities Act, buried in the omnibus bill, reveal their intentions. The changes open our health facilities to invasion by large, American, for-profit health care providers.

Even so, while Harris believes he can get away with breaking his election promise to maintain health-care funding, he cannot publicly threaten universal coverage. The OMA suggested major de-insuring of services as a solution to their fiscal stand-off with the government, and Harris would have no part of it. It is evident that Canadians remain deeply committed to public, universal health care, and the politicians know that they violate this trust at their peril.

This public commitment is the foundation of hope in an otherwise bleak environment. The role of the MRG is to keep emphasizing the enormous human value of our publicly-funded universal access system, and to draw the contrast with the increasingly inhumane system in the United States (see the article by Cliff Rosen in the current issue of ***Medical Reform***). We must expose, at every opportunity, the covert agenda of the politicians who quietly go about undermining universality, and look forward to the day when they can openly advocate a two- tiered system of care. At the same time, we must keep our eye on the bigger picture, recognizing and highlighting the adverse health effects of social service cuts on Canadians' health status. The MRG must stay vigilant and active in what is certain to be a continuing battle for maintaining Canada's most popular social program.◆

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The Social Planning Council of Metro Toronto prepares a range of resources, including SOCIAL INFOPACS. The purpose of Welfare Cuts in Ontario: Punishing the Poor is to examine the recent changes to welfare benefits and eligibility, provide accurate comparisons to other provinces, and examine the likely impact on social assistance recipients and on the Ontario Economy. Available from the Social Planning Council of Metro Toronto, 2 Carleton Street, Suite 1001, Toronto, Ontario M5B 1J3. Telephone: (416) 351-0095; Fax: (416) 351-0107; e-mail <spcmetro@web.apc.org>.

The Paying for Canada Coalition is a joint initiative of the Social Planning Council of Metro Toronto, the Child Poverty Action Group, and Citizens for Public Justice. They publish a series of bulletins on issues relating to the debt, deficit, and social spending. To order those bulletins, contact the Social Planning Council of Metro Toronto, 2 Carleton Street, Suite 1001, Toronto, Ontario M5B 1J3. Telephone: (416) 351-0095; Fax: (416) 351-0107, e-mail <spcmetro@web.apc.org>.