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# Medical Reform

Newsletter of the Medical Reform Group

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## MDS' GROUP SHOULD STAND FIRMLY BY MEDICARE: CANADA'S DOCTORS HAVE CHANCE TO LET US KNOW IF THEY STAND FOR EQUAL TREATMENT FOR ALL

By Irfan Dhallia

This week, the Canadian Medical Association faces an historic choice. In a planned debate on privatization, the nation's doctors have the opportunity to decide whether they stand alongside their patients in the effort to preserve equitable health care for all Canadians.

Last month's Supreme Court ruling to permit private health insurance in Quebec makes the CMA debate particularly critical. Even before that decision, the agenda of the doctors' annual meeting in Edmonton included resolutions that appear to call for increased health-care privatization. After the Chaoulli decision, a 4-3 Supreme Court ruling arguing that waiting lists in Quebec have become so long that citizens cannot fairly be denied the opportunity to purchase private insurance, the doctors have added a special session to their meeting.

The agenda and background information for this session are for doctors' eyes only; while much of the information on the CMA website is available to the public, only physicians can read what the CMA's lawyers think of the Chaoulli decision.

So far, the CMA has officially stood behind the Canada Health Act's principles. Intervening in the Chaoulli case, it argued that there are "strong indications that solutions exist in a public health-care system that will extend a commitment to timely access to medically necessary health care."

But at the same time, some representatives of the CMA have made statements that cater to the small but vocal camp of physicians who clamour for increased health-care privatization.

Albert Schumacher, current president of the CMA, just last

month told the British Columbia Medical Association that "private health care is not some bogeyman to be trotted out during an election campaign. We need a real debate on the role it has played, continues to play and will play in our system to advance the health of all Canadians."

For years, the call for debate has been a cover for attempts to undermine medicare. In fact, Canada has had the debate repeatedly, culminating in the Kirby and Romanow reports of 2002. Both of these well-researched documents concluded that public funding of universal health care is not only more equitable, but also more efficient than private alternatives. Medicare plays an important role in producing Canada's overall health outcomes, which are among the best in the world.

After studying the full range of health-care systems around the globe, Roy Romanow concluded that Canadians would be best served by a reinvigorated medicare in which governments continue to fund care and public, or non-profit providers continue to deliver it to all Canadians under uniform terms and conditions.

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# Medical Reform

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Articles and letters on health-related issues are welcome - please send to:

medicalreform@sympatico.ca

Contact us at:

Medical Reform

Box 40074, RPO Marlee, Toronto, ON, M6B 4K4;

Phone: (416) 787-5246;

Fax: (416) 352-1454;

E-Mail: medicalreform@sympatico.ca

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Editorial committee this issue:

Brad MacIntosh, Janet Maher

The Medical Reform Group is an organization of physicians, medical students, and others concerned with the health care system. The Medical Reform Group was founded in 1979 on the basis of the following principles:

**1. Health Care is a Right.**

The universal access of every person to high quality, appropriate health care must be guaranteed. The health care system must be administered in a manner which precludes any monetary or other deterrent to equal care.

**2. Health is political and social in nature.**

Health care workers, including physicians, should seek out and recognize the social, economic, occupational, and environmental causes of disease, and be directly involved in their eradication.

**3. The institutions of the health system must be changed.**

The health care system should be structured in a manner in which the equally valuable 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 is provided.

## MDS' GROUP SHOULD STAND FIRMLY BY MEDICAL CARE (continued)

Proponents of privatized medicine point to countries like France, Germany and Sweden, all of which tolerate a small, tightly-regulated private health-care industry. But what the privatization proponents do not tell you is that countries like France, Germany and Sweden fund an even greater proportion of health-care expenditures from the public purse than does Canada.

And, unlike those three states, we share the world's longest undefended border with a country that believes personal liberty should always trump the collective pursuit of happiness.

Romanow discovered that Canadians take a more balanced approach, and that's why he entitled his report Building on Values. A significant private sector role in our health-care system would resemble the Houstonian model much more closely than the Parisian one - massive corporations with megabuck CEOs, geographically removed 9-to-5ers making clinical judgments on behalf of shareholders instead of patients, and pervasive marketing campaigns that will be so dominating that our very values may change.

The CMA last visited the public-private debate 10 years ago, and came to the right conclusion.

One of the most vocal supporters of the Canada Health Act

was Dr. Ruth Collins-Nakai, a pediatric cardiologist from Edmonton. Here's what she told her colleagues: "Who would benefit from increasing privatization? Those who could afford private health care, and those who provide it, including doctors and insurance companies. But, the majority of people could not afford private care, and they are the vast majority requiring the most care.

"So, the minority of patients, the wealthy, would pay for more choice, and the majority of patients would receive less choice and less quality in the public system as the private system gradually skimmed (off) the best physicians, equipment, facilities and other health-care providers." Never heard of Collins-Nakai? You will. She's smart, she's a natural leader, and she's an Albertan.

This week she also takes over as president of the CMA. Let's hope for the sake of ordinary Canadians that Collins-Nakai is as eloquent in 2005 as she was in 1995, and that she is able to persuade the CMA's delegates that solutions to our health-care system's problems are attainable within the public system.

Then our nation's doctors will truly be standing alongside their patients. ♦

*Published as an op-ed by the Toronto Star, Monday, August 15, 2005.*

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# THE CANADIAN MEDICAL ASSOCIATION AND PRIVATE CARE

The Canadian Medical Association recently released a poll which showed that fifty-eight per cent of physicians feel most of their patients will either not qualify or won't be able to afford private health insurance.

Albertans should listen carefully when their most immediate health care provider expresses concern, based on experience, with the possible outcomes of privatization initiatives such as Premier Klein's Third Way supplemental health insurance plan.

In a recent column, the Premier stated the Government of Alberta has both a legal and moral responsibility, based on the Supreme Court of Canada's decision in the Chaoulli case, to embrace health care privatization.

Whether through private supplementary insurance plans or private delivery, Premier Klein said he wants to move swiftly to remove barriers to access health care.

Unfortunately, the Premier's rationale is based on a misunderstanding of the Supreme Court's decision, a willful ignorance of international evidence, and an understanding of choice that only affluent Albertans will be able to enjoy.

The fact is the Canada Health Act is still the law of the land. While the privatization lobby has pounced on the Supreme Court's decision as spelling the death of Medicare, the legal effect of the court's decision is limited to Quebec.

Provinces can maintain a single-tier system, including Quebec. Even Justice Deschamps, one of the Justices who ruled in favour of Chaoulli, stated "In this regard, when my colleagues ask whether Quebec has the power under the Constitution to discourage the es-

tablishment of a parallel health care insurance plan, I can only agree with them that it does."

Proponents say private health care is the solution to waiting times. But the international evidence is overwhelming that a parallel, private health system does not relieve pressure on the public system.

At the end of Alberta's Symposium on Health, which was held in Calgary this past May, Health Minister Iris Evans admitted the majority of speakers cautioned that private financing and for-profit delivery is no cure for health issue like waiting lists. Countries with two-tier health systems like New Zealand and Britain struggle with long waiting time. The reason is that physicians working in the second tier of private health care will come from the already stressed public sector. It is a case of stealing from Peter to pay Paul.

If Canadians think they will have more choice under a two-tiered system, they should think again. Our public system allows individuals to choose their physician. In many other countries, such as the United States, your insurance company tells you which physicians to visit.

Insurers also dictate the conditions under which you receive health services. For instance, the insurer may not cover the entire costs of the prescribed health care services. As with auto insurance, you would be left paying the deductible. Barriers to getting insurance are compounded for pre-existing conditions or following a serious accident or illness.

It must also be noted that Medicare is a significant economic competitive advantage for Canadian business. According to Michael Grimaldi,

President of General Motors of Canada, medical coverage for employees and retirees costs GM Canada about \$500 per vehicle, three time less than the American operations cost of \$1,500. That's why GM is expanding in Canada while at the same time eliminating 25,000 jobs in the US.

The Canadian Medical Association will have its annual meeting August 14-17 in Edmonton. The agenda includes a debate on "the full range of issues surrounding the public/private interface in the health care system."

Older physicians remember that Canada use to have a completely private health care system, both for insurance and delivery. Patients often did not seek medical treatment because of the cost or families went bankrupt to pay their loved one's medical bill.

It was also a time when doctors co-signed loans for patients or received payment through an in kind service. There were also times when service was given freely because of the physician's moral commitment to his or her patient.

I urge my fellow practitioners and all Albertans to weigh carefully the benefit of our public health care system. It is a system that remains committed to equal and timely access on the basis of need and not of wealth.

Medicare came into existence because of the painful experience of our parents and grandparents. If we choose to ignore our history, we will be condemned to repeat it. ♦

*Published August 9, 2005 in the Edmonton Journal and the Calgary Herald and reproduced here with permission of the Friends of Medicare. Dr. Avalon Roberts has a community practice in psychiatry in Calgary and is the Chairperson of the Friends of Medicare.*



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# A FRIENDLY DEBATE ON THE CHAOULLI DECISION

**W**as the Supreme Court right to knock down Quebec's ban on private medical and hospital insurance for services covered by medicare and the ban on private medical services in private hospitals by physicians who are not participating in medicare? Arguing **NO** is Dr. Gordon Guyatt of the Medical Reform Group. Arguing **YES** is Dr. Edwin Coffey who was an expert witness for Chaoulli and Zeliotis in the Supreme Court case and is a senior fellow at the Montreal Economic Institute.

**NO:** The Supreme Court decision that purports to defend Canadians' rights to prompt health care places the rights of the affluent above those of ordinary Canadians.

As the court's minority opinion acknowledged, both the Romanow and Kirby reports concluded, after exhaustive study, that a parallel private system leads to deterioration and longer wait times in publicly funded care. Subsidized by additional funding, a parallel private system draws health personnel from publicly funded institutions. This is particularly worrisome in Canada, where privately funded care will exacerbate the current shortage of both doctors and nurses. Britain and British Columbia show us the likely immediate consequences. Private clinics will cherry-pick low risk patients for relatively simple surgical procedures and leave publicly funded institutions to deal with both sicker patients and the private clinics' complications. Specialists in demand, ophthalmologists and orthopedic surgeons, for instance, will devote less time to deal with those dependent on publicly funded care. Australia and the U.S. demonstrate what will happen if the process extends further: long waits and poor care across a wide range of services for those without high-priced private insurance. By

undermining publicly funded services, the decision compromises ordinary Canadians' rights to equal access to high quality health care.

**YES:** My debating opponent is unhappy with the June 9 Supreme Court judgment. He would prefer a continuation of the public sector monopoly in the financing, insuring and delivery of essential medical and hospital services. He opposes the effective restoration by the Supreme Court's decision of a parallel private medical, hospital and related insurance sector (private alternatives) for services presently covered by medicare.

His arguments have been raised endlessly in the 'public versus private' debates involving medical associations, political parties, think tanks and commissions. They were used in this court case by the attorney-generals of Quebec and Canada, by their five expert witnesses and by interveners such as the Canadian Labour Congress, all of whom defended the legislative prohibition of private alternatives. The underlying claim, that private alternatives would harm patients in the public system, was unsubstantiated by worldwide evidence, especially from continental Europe. As expert witness for the appellants Chaoulli and Zeliotis, my conclusions in this matter and those of the Supreme Court were in accord.

With private health system funding, innovation and experimentation again legalized in Quebec and Canada, parallel or mixed systems will offer a full range of medical, hospital and related insurance services of the same high quality that continental Europeans enjoy.

**NO:** Far from the monopoly Dr. Coffey suggests, the public sector has little role in delivering health services.

Canadian hospitals are private not-for-profit institutions, and doctors' offices exclusively private.

The French smoke more than Canadians, but have lower rates of coronary artery disease. Canadians can therefore reduce their risk of coronary disease by smoking more, right? Dr. Coffey's logic is equally misleading. To the extent that European health-care systems succeed, Europeans feel their systems are in crisis, it is despite allowing small private-pay sectors.

There are several reasons Europeans withstand their private-pay sectors better than Britain, Australia and the U.S. withstand theirs. Europeans rely more on public funding than does Canada: 75% to 85% versus 70%. The European private-pay sector is very small and tightly regulated. It is set within a society with less inequality between rich and poor, stronger social services and without a NAFTA agreement that allows invasion by U.S. health-care corporations.

When Canada follows European models, increases the proportion of health care funded publicly, institutes national pharmacare and home care and a massive investment in public housing, we too might tolerate a small, heavily regulated private pay sector with relative impunity. Far better just to avoid the problem.

**YES:** Contrary to Dr. Guyatt's claim, that the public sector plays a minor role in the delivery of medical and hospital services. I suggest that its role is a very powerful one. He who pays the piper usually calls the tune. In this case, the public piper pays 98% of physicians' revenue from delivery of medical services and 93% of hospitals' revenue from delivery of hospital services. The public piper also sets the prices, terms and conditions for delivery of serv-

*(continued on page 5)*

## FRIENDLY DEBATE (continued)

ices, one of which has been the rationing of public funds, physicians, nurses, diagnostic and treatment facilities.

This has contributed to the impoverishment and deterioration of Canada's medical and hospital systems. The main culprits in the successful Chaoulli and Zeliotis Supreme Court challenge, were the illegal clauses in Quebec's medicare legislation, that prohibited private alternatives in medical and hospital services and insurance, and infringed the individuals' right to life, liberty, inviolability and security.

These monopolistic legislative clauses were invalidated by the court's judgment. This is a momentous victory for patients, physicians and all future consumers of medical and hospital services and insurance, who treasure the opportunities and responsibilities of health-care freedom that is restored, while still retaining universal medicare coverage. ♦

*MRG Steering Committee member Gordon Guyatt engaged in an exchange of opinion on the Chaoulli decision with Dr. Edwin Coffey, published in the July 19, 2005 issue of THE MEDICAL POST*

## KLEIN WAY THE WRONG WAY, DOCTORS SAY

The Medical Reform Group, an organization of physicians devoted to maintaining a high quality publicly funded, universal health care system, today denounced Ralph Klein's move toward two tier Canadian health care.

"Klein's Health Minister, Iris Evans, says that medically necessary services will still be covered," MRG spokesperson Dr. Gordon Guyatt said.

"Does Evans believe that more expensive hip replacements, or podiatry care, lead to better health outcomes or not? If she does, then they are medically necessary and should be covered. If not, allowing private insurance for useless treatments means sanctioning a scam".

When pressed by reporters on the need to undercut universal, public health care, Klein pointed to Alberta's health care expenditures.

"The money issue is fundamentally a lie," said another MRG spokesperson, Ahmed Bayomi. "First of all, Canada is still spending 10 per cent of its GDP on health care, the same percentage as in 1992.

Second, if we are worried about health care expenditure, two tier is the wrong way to go. Every study that has ever compared the two shows that publicly funded health care is less, not more expensive. It's the private Klein-way that is the road toward uncontrolled spending."

Indeed, it's ironic that Klein's announcement comes on the same day as the latest report on the disastrous effect of private pay, and private insurance, on health care costs. A just-released study of heart by-pass shows Americans pay twice as much, with health outcomes that are no better.

"Perhaps the biggest irony is that the provincial health symposium Klein held in May told him what every health policy expert knows: private pay is more expensive, and less equitable," Guyatt concluded. "Klein-way represents a triumph of ideology over evidence and good sense." ♦

*Released July 13, 2005 by the Medical Reform Group.*

## IDEOLOGY TRUMPS EVIDENCE

*Gordon Guyatt responded to Globe Editorial, "Straight Talk on Health," of Saturday, July 20, 2005*

Advocates' of private health care - including Quebec's Dr. Couillard and the Globe editorialists - appear determined to ignore the relevant evidence. The highest quality studies show that, when public money funds investor-owned for-profit hospital or outpatient care, death rates rise. The latest studies show Canadian for-profit nursing homes deliver lower quality care than

not-for profit institutions, and confirm that American for-profit hospitals fail quality standards more often than not-for-profit hospitals.

The studies that demonstrate these findings have passed rigorous peer review and been published in the highest quality medical journals. When Ralph Klein invited worldwide experts to an Alberta conference earlier this year, this is the news he heard.

He also heard that if private health insurance comes to Canada, the result will be administrative waste that will gobble up millions of dollars that should go to delivering health care.

But none of this seems to matter. Ideology still trumps evidence. Too bad for Canadians. ♦

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# CMA PRESIDENT BETRAYS CANADIANS

The Medical Reform Group today expressed profound disappointment over CMA president Albert Schumacher's support for two-tiered American style care in Canada.

"Doctors who are on patients' side will support universal, publicly funded health care," said MRG spokesperson Gordon Guyatt. "Doctors who understand the evidence, and realize that publicly funded health care is more efficient, will support universal publicly funded health care."

In his publicly quoted comments in the Toronto Star, Dr. Schumacher lumps publicly insured and uninsured services together. We

already have insurance available for uninsured services such as dental care, and as long as these remain uninsured that is appropriate. Insurance for publicly insured services, on the other hand, will severely undermine equitable care for all.

"An upper tier of care will suck physicians and other resources from the publicly funded system," said another MRG spokesperson, Dr. Irfan Dhalla. "The result will be an increase in problems, including wait times, for publicly funded care."

The questions Canadians should be asking themselves is if they want high quality care for all, or only for those with higher incomes. Roy Romanow found out that Canadians

place a high value on equity. The current assault on publicly funded health care is a move toward a more selfish, less compassionate American model.

"Dr. Schumacher is advocating better care for the wealthy, and changes that will lead to worse care for the rest of us," Dr. Guyatt concluded. "In doing so, he is putting himself on the side of the privileged and profiteers ready to take millions of dollars that should go to health care and put it in their pockets. In doing so, he is betraying the ordinary Canadians whom doctors should be protecting."♦

*Released August 15, 2005 by the Medical Reform Group*

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## A CAUTIONARY TALE: BRITAIN'S EXPERIENCE WITH PRIVATE HEALTH CARE

*The UK has been held up by many as one of the success stories in the privatisation of health care services. In this open letter of August 15, 2005 to President-elect of the Canadian Medical Association, Dr. Ruth Collins Nakai, Peter Fisher, President of the NHS Consultant's Association and Jacky Davis, consultant radiologist and member of the NHSCA Executive Committee, paint a rather bleaker and more worrying picture.*

We are writing this open letter to Canadian doctors as representatives from the Canadian medical profession gather at the general meeting of the Canadian Medical Association. We understand that delegates to the meeting will participate in a critical debate tomorrow about privatisation of public health care.

Those in favour of privatisation often point to Britain as an example of how the private sector can "save" public health care. We are writing, as British doctors, to share what we have learned first-hand about the dangers of private sector involvement in health care, in the hopes that our colleagues in Canada

can learn from our country's mistakes and reject private care and other market-style policies.

The British National Health Service (NHS), one of the earliest and most-studied publicly funded health systems in the world, has been under increasing threat from privatisation for some time. Similar but more recent systems in other countries are now being subjected to the same pressures to privatise.

The NHS has suffered from decades of underfunding relative to other developed countries. As a result, despite its inherent efficiency (before the imposition of market-based policies, administrative costs were less than 6%), critics were able to point

to long waiting lists and ageing hospitals.

To its credit, the current government has finally recognised the underlying problem and announced that spending will rise annually until it reaches the European average by 2008. Indeed, the annual health budget is already double that of 1997. So far so good. But although there have been some improvements, mainly in elective surgery, doctors and the public are puzzled that despite the extra funding there are still shortages in other parts of the service, with hospitals having to close beds and whole units to avoid financial deficit.

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## A CAUTIONARY TALE (continued)

The answer to this puzzle is that much of the additional money is being diverted from its proper purpose – that is, providing front-line care – by the government’s other policies. Presented to the public as “modernisation,” these include payment by results, Private Finance Initiatives (PFI), competing providers, and the “patient choice” agenda.

Firstly, the money is going into private profit. Short-term improvements in easily counted and politically important areas like waiting lists are being achieved by expensive deals with the private sector. These include not only using spare capacity in existing private facilities, but now the establishment of “independent sector treatment centres” (ISTCs), often owned and staffed by foreign commercial concerns.

These ISTCs are offered long-term contracts with guaranteed income – at costs up to 40% higher than the NHS. They “cherry pick” the simple cases and have little responsibility for complications or followup. Their clinical governance arrangements are currently unclear and there are already concerns about the quality of care in ISTCs.

The removal of much elective surgery from the NHS is putting training in some specialities at risk. Because fewer of the low-risk cases are being seen in NHS hospitals, young surgeons are no longer getting the training they need. In addition, the concentration on short-term episodic care is diverting attention and funds from the majority of patients, whose needs are for the longer-term management of chronic disease or disability.

The concept was initially “sold” as a short-term measure to tackle the backlog until the NHS was

able to take on all its commitments but it is now clear that the government intends the growing private sector to remain and compete with the publicly provided NHS, frequently on an unfair basis. The resulting “contestability” is seen by the government as producing a “creative discomfort” which will improve the service. There is no evidence to support this assumption. There is, however, mounting evidence of the problems it is causing. Yet, the government has said that it is quite prepared to see units and even entire hospitals close under the new competitive regime.

We believe that you have already experienced PFI (known in Canada as P3s or public private partnerships) for hospital construction. This is another example of governments choosing quick, politically useful results without concern for the long-term consequences. Inevitably PFI hospitals are more expensive, as borrowing is at a higher rate and there has to be profit for the shareholders. As a result, our first hospitals were too small. Now, although PFI hospitals must be at least as large as those they replace, many defects are appearing and the repayments – the first charge on the hospital’s budget – are causing financial problems. It is difficult to find anyone in the UK now prepared to support PFI except those in government and those set to profit from it.

Secondly, both financial resources and staff time are being wasted on the bureaucracy inherent in trying to run a competitive market system. The Conservative government introduced “competition” in the early 1990s, and as a result administrative costs doubled. The key feature was the splitting of the service into “purchasers” and “provid-

ers.” While in opposition, the Labour Party opposed the market and PFI. But after gaining power in 1997, they retained both PFI and the artificial separation in which one part of the service (the “purchaser”) has to buy services from the other (the “provider”) which markets and sells them. This purchaser/provider split is the absolutely crucial factor. Without it a market cannot operate, but with it, the service is wide open to privatisation, as we are now seeing.

The hospital service, split into separate semi-independent “Trusts” with boards of directors under the Conservatives, is now to be even more autonomous, as “Foundation Trusts” enter the market with the power to borrow money and sell assets. To repay money borrowed, they will need to attract patients from outside their normal area. As all hospitals are scheduled to become Foundations within the next few years, there will be a very unstable competitive situation with the government accepting that some hospitals may be forced to close. Foundation Trusts will no longer be responsible to Parliament but to an independent regulator – interestingly, exactly the system which governs our now-privatised railways, telephone, gas, electricity and water industries.

“Payment by results” means that every item of treatment will be marketed, sold and billed for. The public sector will find it hard to compete with the private sector on this basis as the latter does not have to provide expensive emergency and intensive care. The private sector is also not responsible for teaching and training, the costs of which have not been factored into the tariffs.

The government rhetoric is that we must have a diversity of provid-

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## A CAUTIONARY TALE (continued)

ers, which it justifies as promoting choice. But the public has demonstrated that its first priority is a good local hospital, without the need to “shop around.” It is the system of local hospitals that is now in jeopardy.

This is indeed privatisation – in fact if not yet in name – although some have suggested that commercialisation is a better description, as even those parts which remain in the public sector are being forced to act like commercial enterprises. These reforms are driven by ideology and there is as yet no evidence that a competitive market improves outcomes in health care.

There is much more we could say. It is important to insist that any new and controversial system is piloted and independently evaluated before, rather than after, its general introduction and that the longer-term effects are fully considered.

Beware the recurrent reorganisations which we have suffered over the years, which have damaged the morale of both clinicians and managers whilst totally bewildering patients and harming care. The most cost-effective system is the simplest – an organisation with a budget to provide services for the people of its area and democratically accountable to them.

In closing, do not be persuaded that any improvements in the NHS are due to the government reforms. The reality is that vastly increased expenditure has produced only modest results precisely because of privatisation and commercialisation’s negative effects.

We welcome any opportunity to further share our experiences and research with you, and hope this letter can initiate a meaningful dialogue and exchange about these critical issues. ♦

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## WHICH DOCTORS WANT PRIVATE HEALTH CARE?

*Member Richard Pickering responds August 15, 2005 to Toronto Star reporter Karen Palmer’s August 13th article, “Doctors want private health care”*

**T**he position of Dr. Schumacher from the Canadian Medical Association is reminiscent of the position of most doctors and the Saskatchewan Medical Association in the 1960’s when Tommy Douglas introduced Medicare in Saskatchewan. In 2005 we once again have a small special interest group attempting to promote policies which are in the interest of the few and privileged but not in the best interest of the majority of Canadians.

Fortunately for Canadians, the Saskatchewan Medical Association and the physicians who opposed the introduction of public medicare did not prevail in 1961 thus paving the way for universal publicly funded medicare for all Canadians; we must not allow special interest groups like the CMA to undermine the equity and universality of medicare in 2005.

The Romanow Commission Report clearly shows that the solutions to problems in our health

care system remain in the public domain. It is time for Governments to respond to all of the Romanow Commission recommendations. ♦



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# HAMILTON HEALTH COALITION PLANS FOR PLEBISCITE ON FOR-PROFIT HEALTH CARE

*Janet Maher with files from Ted Haines and Richard Pickering*

Just as the last issue of *Medical Reform* was being printed, a coalition of community groups in St. Catharines, Ontario announced the results of a plebiscite they had organized in response to provincial plans to build a new hospital in their city. At the end of a day of polling at various work and residential locations in the community on June 25, 2005, organizers reported that over 12,000 people had voted on the resolution: "I support a new hospital for St. Catharines that is 100 per cent publicly funded, owned, administered and operated. Keep our hospital public and non-profit." Of those 98 per cent voted YES. The vote has captured the attention of the politicians.

It seems that the Ontario Liberal government is now planning to create P3 hospitals in Hamilton. This is a serious problem. The Hamilton Health Coalition (HHC) is working, in collaboration with the Ontario Health Coalition, to organize a citizens' plebiscite on P3 hospitals like the one held in St. Catharines in June. The plan is to conduct an election style campaign working toward a voting day sometime in November to give Hamiltonians a chance to vote against this.

The goal of the HHC is to inform and mobilize as many people as possible to be involved in the campaign (to begin on September 20th) by whatever means we can. They have a web site at <http://www.hamiltonhealthcoalition.ca> and several MRG members in the Hamilton area have already committed energy to the campaign.

## **What's wrong with P3s?**

In January 2001, as one of his first acts as Ontario Minister of Health, Tony Clement traveled to the United Kingdom to investigate the restructuring of the British National Health Service. He came back with a new model of hospital development, the so-called 'public private partnership' (P3).

Currently most Ontario hospitals are owned and operated by non-profit hospital boards funded by our taxes. In the new model, a for-profit group of corporations—a consortium—designs, builds, owns and operates the hospital and leases it back to the hospital board for a period of 20 to 60 years. Under this arrangement, in addition to the lease expenses, a significant portion of the tax dollars allocated to support the hospital is funnelled into the pockets of investors. Moreover, because the hospitals are owned in the model by private for-profit companies, the institutions will be less accountable to public scrutiny.

## **The Ontario Experience with P3s to Date**

The cost of the Brampton privatized P3 hospital has almost doubled since the P3 project was first announced in 2001 and it isn't yet completely open. The cost has gone up from approximately \$350 million to over \$550 million. The size of the overall deal is extraordinary. In total, including the building and private contracts for services, the deal amounts to over \$2.6 billion. An independent economist reports that the cost is \$174 million higher (net

present value) than if the hospital were to be built publicly. This higher cost includes only the higher borrowing rate for private corporations (compared to the government) and does not include higher costs due to profit-taking, legal and consulting or other fees, since these are and will remain secret.

Despite repeated claims by P3 pushers that their projects are faster, better, cheaper, the Brampton project is well over a year behind schedule, more expensive than planned, and the size of the planned facility has shrunk. The Royal Ottawa Hospital P3 project is also significantly behind schedule and costs have escalated from \$100 to \$125 million.

## **For profit P3 hospitals mean less service.**

- ◆ The added expense of the buildings means cuts have to be made to clinical services. On average, privatized P3 hospitals have 20 per cent fewer beds than they would have if they were fully public.
- ◆ The UK experience with staffing in P3 settings indicated they operated with 11 per cent fewer physicians and 14 per cent fewer nurses in order to generate profit for investors. Not surprisingly, infection and mortality rates are related to lower staff ratios and less training in clinical and non-clinical areas.
- ◆ Despite the loss of community control over large parts of the health care system facilitated by the P3 model, which often involve

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# DR. MIMI DIVINSKY AWARDED THE NORMAN BETHUNE MEDAL (1ST CLASS)!

*Tenant Action Group Belleville*

**O**n August 7th the Tenant Action Group (Belleville) opened our first “Hunger Clinic” in a housing project here in Belleville. Throngs of low income people - some cancer ridden - showed up to be assessed by Doctor Divinsky.

Two hundred hamburgers later (paid for by a charity car wash put on by the kids of Marsh Drive) 124 people were assessed for the “special diet” allowance as allowed by the Ontario Works & Ontario Disability Support Program.

This allowance gives a qualified health care professional the ability to prescribe special diets to those in need. These Acts allow for an extra \$250 per social assistance recipient, and each of their dependants - monthly - above and beyond their normal welfare cheque! The “Hunger Clinic” is part of the “Ontario Raise The Rates Campaign” organized by the Ontario Common Front.

The Tenant Action Group (Belleville) is an Anarchist collective of working class people in Hastings County. We are a “direct action” militant anti-poverty group affiliated with like minded organizations under the umbrella of the Ontario Common Front (OCF) - whose affiliations include Peterborough, Kingston, Ottawa, Toronto, Guelph, Kitchener-Waterloo, Sudbury and other locations. The Ontario Common Front has engaged in numerous squat actions, refugee solidarity protests, anti Bush, anti-militarism, Anti - G-8 - IMF - FTAA - WTO and other anti-corporate globalization campaigns. We operate nationally within

a loose network from Halifax to Vancouver - and all spots in between.

Our group deals daily with evictions, hydro cut-offs, police harassment and bad bosses - issues impacting on the everyday struggle of working class people. A huge majority of our members are single moms caring for the kids, organizing actions and struggling to survive - while at the same time dealing with arrests and other forms of state harassment.

The Tenant Action Group (Belleville) followed Toronto’s example and pushed for province wide “Hunger Clinics” whereby people on social assistance could obtain an extra \$250 per person in the family per month - above and beyond her regular welfare cheque, if a doctor, dietician, nurse or midwife signed a form prescribing the “special diet allowance”. Last May the Canadian Federation of Students paid for 40 people from Belleville to travel to Toronto to take advantage of a “Hunger Clinic” put on by the Ontario Coalition Against Poverty (OCAP) and the Regent Park Community Health Centre.

After our clinic closed its door on the 7th of August the extra money has started rolling in and the difference this extra money has made is incredible!

It is a no brainer that people on social assistance cannot pay the rent and feed the kids! Yet government after government refuse to do anything! Poor people think little of doctors, dieticians, midwives or nurses who miss the link between poverty and poor health. Our group

went to the local Health Unit to try to enlist the support of the dieticians there for our own “Hunger Clinic” and this professional reamed off a million excuses why she couldn’t ethically help us: Ok, so you specialize in nutrition and somehow, with all your learning you can justify allowing people to starve?

And let there be no doubt: we go hungry!

When Doctor Mimi Divinsky contacted our group to offer assistance we were stunned. Our health care provider backed out at the last possible minute and Mimi stepped in and saved the day!

Local doctors are dead against the clinic; either they refuse to fill out the forms, are ignorant that the allowance exists, or prescribe a paltry \$40 for a diabetic - grudgingly prescribing the special diet allowance in its narrowest interpretation. Welfare workers are mum about the allowance.

Our clinic processed 124 people in desperate need! In fact we have now obtained the help of a local doctor and will hold another clinic two weeks after the first! Already we are overbooked. The people organizing the clinic are welfare recipients themselves taking an incredibly brave stand - one single mom was asked by her caseworker to tell them when the second clinic was to occur and was told that if she supplied this information that she would then be processed for the allowance.

Another single mom, and an organizer with the group, had her welfare cheque held back until she attended a meeting with her worker.

*(continued on page 11)*

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## DR. MIMI DIVINSKY AWARDED THE NORMAN BETHUNE MEDAL (1ST CLASS)! (continued)

She was not told the reason for the appointment and when she arrived was grilled about the clinics. Hastings County has stated that they intend to “dismantle” our “Hunger Clinic”.

The Tenant Action Group (Belleville) was delegated by the Ontario Common Front to organize similar “Hunger Clinics” across the province. The purpose of these clinics is to bring immediate and substantial relief to those most in need. Also, anti-poverty groups across Ontario hope to shame the government of Ontario into raising welfare and dis-

ability rates so that people can live with a semblance of dignity...and we will not wait any longer for government action!

People in poverty are now taking direct action against unjust authority and hypocrisy and learning how to organize and stand together! At one point Hastings County refused to process any of our special diet allowance applications signed by our doctor. We held an emergency meeting where tenants gathered in large numbers to plan a response. The group decided to march on the local

welfare office and occupy it until the bureaucrats saw reason. That very next day Hastings County backed down stating that the last thing they wanted was an “action” against their office. Since that time the County and our doctor are co-operating in processing our claims.

If you are a doctor willing to spend one day taking a medical and political stand then please contact us today! Are there any modern day Bethunes out there? ♦

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## HEROES IN THE SPECIAL DIET CAMPAIGN

*Janet Maher with files from Irfan Dhallal*

As reported in the last issue of **MEDICAL REFORM**, the staff at Regent Park and the Ontario Coalition Against Poverty have been leading an effort to openly bend/break the rules and obtain the Special Diet Supplement for any claimant who wants it because welfare and disability payments are too low to get by on.

According to physician Tara Kiran, one Nurse Practitioner at Regent Park (Cathy Hardill) is singlehandedly responsible for signing up over 1,000 claimants. At \$250 per claimant per month, you can see how this is getting expensive for the city.

Because most of these clinics have been led by Nurse Practitioners, the city, concerned at the increased use of the Special Diet Supplement, came up with a strategy which has had the effect of limiting or at least slowing down its use.

In mid-July, the City announced that as of August 1, 2005, all individuals who are claiming the Special Diet Supplement will need an MD to sign their form.

Beyond the very short notice, which will result in huge inequities at the city offices, this move comes at a point at which many low income residents have little or no access to a family doctor, and so will add pressure to a system that is already seriously overloaded. Given the level of organization of the Hunger Campaigners, however, this is likely only a temporary obstacle, and the campaign is gaining a traction that will soon be very difficult to stop.

The staff at Regent Park strategized about this issue in late July and since then attempts have been made to try and get the Ontario Medical Association to endorse the campaign. At press time, talks are still going on.

In the meantime, however, the MRG Steering Committee has endorsed the campaign. Indeed as many of the following items indicate, many of our members have been active both on the front lines and in the strategy and letter writing campaigns.

Two Steering Committee members, Tomislav Svoboda, Medical Director at Seaton House, one of the best known men’s shelters in Toronto, and Gary Bloch, a newly qualified family doctor from St. Michael’s Inner City Health Unit, have designed educational materials and protocols aimed at facilitating the assessment process and reassuring health care providers that the project is both practical and worthy.

If you would like more information than we have been able to include in this issue, please contact Janet Maher at the MRG office. ♦

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# MAKING ADVOCATES OF PHYSICIANS

*Janet Maher spent an hour in conversation recently with newly graduated physician Gary Bloch, who has been leading much of the medical side of the Special Diet campaign, and here is some of what she learned, beginning with his response to the generic question, who is Gary Bloch.*

**S**o you want to start at the beginning ... I warned you I hate talking about myself ... I studied history before medicine, and I know writing history is about reframing a story to make a point, but here goes:

I grew up in Vancouver with my South African parents, a physician mother and a psychologist father. My family history is heavy in role models for physicians involved in support and advocacy for underserved populations. My mother is a family physician in a free clinic for youth in Vancouver. My Mom's parents did similar work in South Africa until their eighties. My grandmother, after escaping Germany months before the start of the Second World War, trained as a physician and spent her professional life working for poor South Africans of colour.

I cut my teeth in progressive ideas with a left wing Jewish youth movement in BC that was strongly youth-driven and empowerment-oriented. My undergrad degree was in African and colonial history at McGill. After McGill, I traveled for half a year in West and South Africa and soon came to the conclusion that I needed to do something a little more hands on than academia promised, and accepted the offer of medical school admission at UBC.

As you know, UBC is pretty conservative and the medical school is especially so. However, as I already had a good idea what I would do with my training, I took every possible opportunity to work in Vancouver's inner city. After my first year a twist of luck led me to meet the two people who have been my main To-

ronto mentors—Philip Berger and Tomislav Svoboda in the St. Michael's Department of Family Practice, and both of course MRGers.

Ever since I went to medical school I have been focused on being a primary care family physician. It provides me an enormous opportunity to exercise the advocate role on a daily basis. I take the advocacy mandate described by the College of Family Physicians and the Royal College in their statements of core competencies seriously.

Although inner city health is an issue in many parts of the country now, I feel privileged to be able to work in the place I think has the most supportive environment for learners, the most cohesive community of providers, and is tackling some of the most exciting political challenges at the moment.

At this point I am at a transition, having recently completed my residency at St. Michael's and beginning to create a practice at Seaton House (with Tomislav) and at the 410 Sherbourne clinic of St. Mike's. I am young and developing, and the Special Diet campaign came just as I was thinking more intensely about how to incorporate bigger-level politics and advocacy into my practice in inner city health. My current set-up is just about perfect for giving me the time and space to study and explore and to begin to define a place in the medical world that reflects my vision of health and health care.

**JM: How did you come to take on the OCAP special diet campaign?**

In some ways much of my adult professional life has been con-

text-setting for this campaign, and I am so happy to have had this opportunity fall into my lap. As you know, the Special Diet campaign was not initially a medical campaign, and would not succeed if it were only a medical campaign. This is a campaign that holds the ultimate goal of raising welfare rates across the board in Ontario, and of ending poverty.

The campaign involves a previously little-advertised section of the welfare legislation that allows health care providers to approve a "special diet supplement" for recipients of social assistance. This provides for up to \$250 a month extra per recipient, including for dependent children. Welfare rates in Ontario were drastically cut about ten years ago, and have been falling in a relative sense since then, leaving social assistance recipients now with about a third less spending power than they had then (and that wasn't exactly enough to live on).

On average, people living on social assistance now receive funds equivalent to less than half of the poverty line. This is not nearly enough money to allow for a nutritious diet or a healthy lifestyle. This means that every single recipient of social assistance is at high risk for serious nutritional deficiency, by virtue of their poverty. This risk has been demonstrated in studies of welfare recipients in Toronto and eastern Canada. Because of this high risk, and because of the well-established link between poverty and ill health in many forms, I believe every person on welfare has a solid medical reason to be prescribed the full special diet supplement.

*(continued on page 13)*



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## MAKING ADVOCATES OF PHYSICIANS (continued)

The so-called “medical conditions” required to justify these diets are not outlined by the government, but from the diets the form offers, they clearly include asymptomatic risk states like hypertension and hyperlipidemia. Poverty, and in this case fairly extreme poverty, is a risk at least equivalent to, if not stronger than, these conditions. Even this extra money will not bring recipients close to the poverty line, but it will help.

I think we have an ethical responsibility to use all the tools we are given to fight our patients’ health conditions and risk factors for those conditions. When it comes to poverty as a health condition, the greatest therapy we can offer is money.

The beauty of the campaign is that we are talking about an intervention that directly links improving health with reducing poverty. Although the government gives us a licence to focus on health prevention and risk factor modification, and our colleges talk directly about advocacy as a core competence, health care providers tend to shy away from using these skills for poverty reduction.

The link between poverty and ill health has been proven convincingly over and over again, through robust studies and reviews of studies. This link seems to be independent of any definable obvious secondary cause for ill health, like poor nutrition or stress – poverty itself has been shown to be an independent determinant of health, and probably one of the strongest determinants there is.

We put so much effort and money into studying ways to decrease the risk posed by other determinants of health, like the environment we

live in or family history or ethnic background. Why can’t we put the same energy and resources into poverty?

We get excellent training in virtually everything else in medicine, but when you come right down to it, there is a giant disconnect between sanctioning or promoting an advocacy role and knowing how to do it. There is an enormous leap from knowing what is wrong, and knowing how to engage in advocacy, especially in any kind of systemic way. Here’s our chance to put these ideas into practice.

**JM: What has been your experience in getting colleagues to come on board?**

The Special Diet campaign was started by the Ontario Coalition Against Poverty, which is the major organizing force behind it, but its success by necessity rests on health care provider involvement. Physicians are not used to working with community level advocacy organizations, and most such organizations have little sense of how to bridge the gap. Getting health care providers to be involved has been one of the greatest challenges in this campaign.

So we have been working on showing health care providers that we should treat this intervention, and treat poverty, as we do any other medical or health issue. This includes collecting the evidence I’ve talked about, and doing research as we go. This is obviously time- and energy-consuming, but there has been a tremendous value in challenging the way we think about medicine and advocacy and I feel really privileged to have been involved.

I think most physicians want to do the right thing. Our training has worked against that a lot of the time. The payment scheme we work in, except at CHCs which are not fee-for-service and which have been the biggest hot-bed of health care practitioner support so far, makes it difficult not to be money-focused, and this campaign has been a lot of incredibly hard work, most of it volunteer. I don’t think volunteering time as medical practitioners is something that’s done often outside of international health work. I don’t see why we can’t apply the same principles and pro bono energy to fighting severe inequities in health at home.

One of the first questions we get from the health care providers we recruit I think is related to a concern that we are counselling something illegal or fraudulent or unethical, and that the individual practitioner is opening him/herself to being sued.

This seems to be one of the most deeply entrenched fears amongst doctors, and the biggest barrier to recruitment. However as I have said, the bulk of evidence points in the other direction. I don’t think there is any basis for legal action, or even College sanction, against us for being engaged in this campaign.

We have incredibly strong evidence to support our position that we are applying a tool the government has given us to a very well accepted health risk and health condition. Ethically, I think it may be worse to not take action here than to actively approve the full supplement. So we still need to do a lot of education with providers, and that is where it has been important to have the time and resources to assemble that.

*(continued on page 14)*

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## MAKING ADVOCATES OF PHYSICIANS (continued)

**JM: I understand you spent some time in Lesotho with Philip Berger. What did you learn there?**

As I have said, Africa has been part of my make-up from birth. I have travelled by myself and with family, but this was the first time I actually had an opportunity to work there medically and it was amazing. You have seen Africa and so you know that there is just no compari-

son – in the depth of poverty and in the ravages of HIV/AIDS. It's beyond belief to see adults and children infected and dying in front of you, and to compare the resources there with those of the first world.

Still I came away much more hopeful that I thought I would. Although the project is literally a drop in the bucket, many of those who got treatment are doing incredibly well.

It was the people who came back to the clinic after a few months on therapy who lifted our hearts and kept us going. There is a light at the end of the HIV tunnel in Africa, but it is still unbelievably faint. I can in no way equate the fight against poverty here with that in Africa, and if I had a truly altruistic soul, I'd be there in a second. ♦

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## SOME RESOURCES FOR THE RAISE THE RATES CAMPAIGN

*Janet Maher with files from Gary Bloch and Tomislav Svoboda*

There is already a good deal of useful information on the effects of poverty on patients. In addition to the fact sheet designed by the Ontario Coalition against Poverty and the Regent Park Community Health Centre, here are a few educational items assembled by the team at Seaton House:

◆ McIntyre L, Glanville NT, Raine KD, Dayle JB, Anderson B, Battaglia N, Do low-income lone mothers compromise their nutrition to feed their children? *CMAJ*, 168 (6) March 18, 2003

◆ Tarasuk VS, Beaton GH, Household food insecurity and hunger among families using food banks. *CJPH*, 90 (2) March/April 1999.

◆ Tarasuk V, Low income, welfare and nutritional vulnerability. *CMAJ*, 168 (6) March 18, 2003.

◆ Vozoris N, Davis B, Tarasuk V, The affordability of a Nutritious Diet for Households on Welfare in Toronto. *CJPH*, 93 (1), Jan.-Feb., 2002.

Dr. Dennis Raphael of the the School of Health Policy and Management at York University has provided a 4-page commentary on the dietary supplement issue, entitled "City of Toronto Targets Poor Children..." The commentary is available on the Ontario Coalition against Poverty website at [www.ocap.ca](http://www.ocap.ca)

The Income Security Advocacy Centre is working with other Ontario Legal Clinics to try and monitor policy and regulation changes. Their website can be found at [www.incomesecurity.org](http://www.incomesecurity.org).

The Toronto Board of Health (and many other municipal public health units) publish an annual fact sheet on what Toronto calls the Nutritional Food Basket. As can be seen at the Toronto website, the average single individual on social assistance would end up \$285 short of the 2004 recommended nutritious food basket:--[www.toronto.ca/health/pdf/nutritional\\_food\\_basket\\_2004.pdf](http://www.toronto.ca/health/pdf/nutritional_food_basket_2004.pdf).

Bloch and Svoboda have also assembled a few additional fact sheets

and protocols and are continuing to update them for Toronto as new information becomes available:

◆ Special Diet Clinic Baseline Patient Profile (2pp.)

◆ Request for Special Diet Allowance for Social Assistance Recipients (1 p.)

◆ Improving the Health of Your Low Income Patients: The Special Diet Supplement and Reducing Poverty in Ontario (2 pp.)

If you cannot locate these or similar documents elsewhere, contact Janet Maher at the Medical Reform Group using the contact information in this newsletter or e-mail at [medicalreform@sympatico.ca](mailto:medicalreform@sympatico.ca).

Since the governing legislation is provincial, these items are likely to be of use to those in other areas. And we hope that information-sharing around the province will strengthen the pressure for provincial policy change to address the fact that despite the relative prosperity we have seen over the last 10 years, none has trickled down to the poorest. ♦

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# MEDICAL REFORM GROUP JOINS THE HUNGER CAMPAIGN

*The Steering Committee wrote Toronto Mayor David Miller and Toronto City Councillors for the first time on July 19, 2005, and encouraged members as well, to express concern about the City's approach to addressing the health needs of social assistance recipients*

**W**e are writing on behalf of the Medical Reform Group with respect to the city's recent policy changes regarding the Ontario Works Special Diet supplement, and the additional pain this move will cause to Toronto's social assistance recipients who, as you know, suffer poorer health than the average Torontonians.

We have a number of concerns we believe you should take into account before implementing such a measure:

1. Limiting the assessment of special dietary needs to physicians is contrary not only to provincial regulations on this issue, but also to the philosophy of multi-disciplinary, collaborative care that health providers and public officials ought to be espousing. Dietary assessment is most definitely within the scope of practice for nurse practitioners and registered dietitians; at the very minimum, professionals with these qualifications should continue to be able to certify that a special diet is needed.

2. Given the current shortage of family physicians, many Ontarians do not have a family physician to call their own. Those on the lower end of the income spectrum and those whose circumstances force them to move frequently are even more vulnerable than those of us with greater means and the kind of life security that comes from continuity of employment or home ownership.

Physicians who work in multidisciplinary practice should primarily be addressing medical problems that only they are trained to deal with; requiring them, rather than dietitians and nurse practitioners, to certify special diets will exacerbate the physician supply problem and is therefore a shortsighted and foolhardy measure.

3. No one pretends that the use of the special diet form can reasonably address the fact that there has been no attention paid to social assistance rates since the Harris reductions in the fall of 1996, and we would like to count on the city

of Toronto as an ally in a longer term solution to this issue. However, avoiding the issue by invoking a change in regulations without consultation only compounds the frustration of advocates and intensifies the anxiety of claimants who had some reason to look forward to a small increase in their resources at the same time as our food banks sound alarms because of low inventories.

Until such time as social assistance rates are set at a level where claimants can reasonably afford a healthy diet, we urge you to return to the city's previous policy whereby a variety of health care professionals could certify special diet claims. As always, we would be pleased and honoured to work with you and your colleagues to persuade the provincial government to review and raise Ontario Works and Ontario Disability Support Program rates so that those forced to live on them can experience at least a modest amount of dignity, and more importantly, need not put their children to bed hungry. ♦

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## THE CITY REPLIES TO THE FIRST LETTER

**O**n July 22, the City of Toronto passed on the decision of its General Manager of Social Services, Heather MacVicar, as follows:

The following provides further information about the verification requirements that have recently been put in place of Ontario Works cli-

ents in Toronto who are requesting the Special Diet benefit. The requirements for benefit eligibility are established by the Province of Ontario and the program is administered by the City of Toronto.

Under the provincial Ontario Works program, a benefit is available to people who have a specific

medical condition that requires a special diet. For example, people with diabetes may have special dietary requirements.

In order to receive this Special Diet benefit, the provincial requirements under the Ontario Works program state that clients must provide

*(continued on page 16)*

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## THE CITY REPLIES TO THE FIRST LETTER (continued)

proof that there is a medical condition that necessitates a special diet.

To ensure that people's medically-based dietary needs are met, clients will need to submit to their caseworker the standard provincial medical form from their doctor or from a Registered Nurse Extended Class-Nurse Practitioner. This medical form will confirm that there exists a medical condition for which a client requires a Special Diet. The form is available from Social Services local offices.

Upon receiving the medical form, any of the following professionals can request that the client receive a Special Diet benefit, using a

standard form that is available in all Social Services offices:

- Registered Nurse Extended Class-Nurse Practitioner—who is registered with the College of Nurses of Ontario
- Registered Midwife who is registered with the College of Midwives of Ontario (midwives can only prescribe pregnancy nutritional allowance, breastfeeding diet, infant formula);
- Registered Dietician who is registered with the College of Dieticians of Ontario
- Medical doctor

The City has no intention of cutting any client's benefits arbitrar-

ily. Every client who requires a Special Diet for a medical condition will continue to receive it. Over the next several months, clients receiving the Special Diet benefit will have their situation reviewed to verify their ongoing eligibility for the benefit.

City staff will continue to work with community organizations and health professionals to ensure that there is clear understanding of the provincial requirements, so that Ontario Works clients with medical conditions can access the Special Diet benefit.

If clients have questions about the Special Diet benefit, they should phone their caseworkers directly. ♦

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## ANOTHER LETTER TO THE CITY OF TORONTO

*As it became clear that the Manager's response had increased, not eliminated the obstacles, we sent a further letter to the Mayor and councillors, with copies to the Medical Officer of Health, provincial ministers and critics, and presidents of the Ontario Medical Association and the Registered Nurses' Association of Ontario reiterating our interest in addressing both short- and longer term issues.*

Further to our letter of July 19, 2005 and your letter of clarification of July 29, 2005, we are again writing on behalf of the Medical Reform Group to express our disappointment with the city's very recent policy changes regarding the Ontario Works Special Diet supplement.

While we appreciate the City's position is complicated by the fact that it is called upon to implement provincial legislation, we are of the opinion that you and your colleagues could offer considerably more leadership to mitigate the effects on the most vulnerable of our neighbours. As noted earlier, the shortage of family doctors is affecting not only rural and northern Ontarians but even some Torontonians, and we have reason to believe that this situation is

more problematic for those at the lower end of the income spectrum.

The July 22 revision of the regulations to make their participation more central to the Special Diet Authorization creates even more bottlenecks than previously, and we do not understand the reason for complicating the process at this time and without adequate notice to recipients and their providers.

We understand that the regulations were designed by the province after some considerable consultation to respect the competence and legislated scope of practice of several health disciplines. Before implementing additional requirements, we think it incumbent on you and your managers to consult on their implications. Once this has been done, it would be helpful to provide

adequate professional development to your regional staff and to offer it to the health care providers most likely to be involved, to facilitate rather than impede the assessment process.

We are now seeking your assurances to a participatory process on resolving those issues as soon as possible.

At the same time, we believe that the recent focus on the Special Diet process has assumed the importance it has both here and increasingly across the province because of the general neglect of the needs of vulnerable Ontarians. In addition to creating uncomfortable pressures for the municipal tax base and regulatory structure which has a limited capacity to respond, Ontario Works recipients are being subjected to greater

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# TORONTO HEALTH CARE PROVIDERS ENUMERATE FRONT LINE CONCERNS WITH CITY RULE CHANGES

*In their response to the protests of front line health care providers on rule changes to limit those authorized to complete the Special Diet forms, the City 'consulted' with a delegation, with limited success, as is demonstrated in their letter to Councillor Mibevc [with copies to several municipal and provincial social service managers, reproduced below. Steering Committee member Mimi Divinsky signed on behalf of the MRG].*

On August 4, 2005, representatives from many community health agencies attended the Special Diet Allowance meeting called by the General Manager of Toronto Social Services, Ms. Heather MacVicar. At the meeting, Ms. MacVicar outlined changes to the application for a special diet allowance for Ontario Works recipients. Ministry of Community and Social Services representatives, Ms. Margaret Mitchell and Ms. Pat and stated that these changes would be implemented on a provincial level.

We, the undersigned, are writing to express serious concerns we have with respect to the revised Spe-

cial Diet Allowance requirements. As health care practitioners specializing in the health care of low income people, it is our opinion that the new requirements have been created to erect additional barriers for already vulnerable people. Our specific concerns are as follows.

We feel that the new requirement to have the "consent to release medical information" signed is redundant. Ms. MacVicar stated that its purpose is to verify the existence of a medical condition. The diet form itself requires providers to sign certifying that each dietary need arises from a medical condition. There is no need to sign two different forms to certify the same fact. Furthermore, completion of the consent form would permit Ministry and city workers complete access to a patient's medical record at any time as long as the patient was a recipient of financial assistance; the breadth of this consent is a violation of the current provincial privacy legislation that governs patient-provider relationships in this province.

In addition, it is confusing because a form originally intended to verify "limits to participation" in Ontario Works is being used being used to try and verify the existence of a medical condition requiring a special diet. Providers are asked to fill out only questions 1 and 3 on the new form. To fill out only part of a form is counterintuitive and it is very likely most providers will fill out the form incorrectly - either refusing to fill out the form in frustration of the

redundant paperwork or filling out the entire form and disclosing an unnecessary amount of medical information to caseworkers.

As well, questions 1 and 3 do not provide information that would be useful in verifying the existence of a medical condition. Question 1 asks providers to state how long they have known the patient; it may unfairly punish patients who must ask an alternate provider to fill out their form because either their regular provider is too busy or because they are not lucky enough to have a family doctor of their own. Question 3 asks providers to disclose the patient's health limitations.

However, many health conditions requiring special diets, such as diabetes and iron deficiency, do not necessarily cause limitations. It is unclear what information Ms. MacVicar would like us to provide in question 3 that could help her verify the existence of a medical condition other than explicitly stating the medical condition - and Ms. MacVicar clearly stated that we are not required to disclose details of the medical condition. Social Services staff were adamant that photocopied forms cannot be used, but only original forms pre-printed with the client's name and member ID number. On questioning, Ms. MacVicar told us that the rationale was that original forms would help ensure that practitioners signing the forms were "authentic." Clearly, the type of form used does not provide any such reassurance. It

*(continued on page 18)*

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## ANOTHER LETTER (continued)

intrusion at a time when their resources are least.

Your Worship, you have gained some considerable respect among Torontonians during your tenure as mayor. We call on you now to provide the kind of leadership to a social services rate review process which will recognize the current needs of our most vulnerable, by going with us to persuade the appropriate provincial authorities to undertake a comprehensive review of Ontario Work and Ontario Disability Support Program rates so that those forced to use those programs can live adequately in one of the most resource-rich spots in the world. ♦

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## TORONTO HEALTH CARE PROVIDERS ENUMERATE FRONT LINE CONCERNS WITH CITY RULE CHANGES (continued)

is our opinion that the use of original forms is intended to create barriers to access to the special diet and it does not appear to be anything other than an arbitrary bureaucratic barrier. We were also dismayed to hear that Toronto Social Services will be reviewing first the special dietary needs of families with “multiple entitlements” which means families with children.

This means that Toronto’s poorest families will be required to have brand new forms completed, restating what was on their previous forms, even if they were assessed as recently as July 2005. This is seemingly discriminatory and again, the logic does not seem evident. In practice, requesting health providers to fill out two new forms, perhaps weeks after filling out a previous form or letter, will not be readily accomplished. This will have the effect of causing poor families with children to lose their entitlements and it is difficult to conclude that this is not the explicit purpose of a clearly unnecessary bureaucratic requirement.

Ms. MacVicar went on to warn that if these “multiple requests” continue they will not be automatically granted but will be taken “under advisement” which may include a third party medical consultation to determine if the medical need is legitimate. This exemplifies an overall theme referred to over the past few weeks in which the integrity of health practitioners completing dietary requests has repeatedly been called into question. We are offended by such insinuations and wish to state categorically that we assess every person appropriately, we document this assessment and complete the forms based on legitimate medical need.

Many of us attended the August 4th meeting in hopes of getting clarification and learning how we can expedite access to needed health supports for our clients. Instead, we are more confused than ever. The logic behind the policy changes seems elusive. Our professional integrity has been repeatedly called into question. Our clients are being arbitrarily denied entitlements, they are being compelled to carry out unnecessary, redundant bureaucratic hoop-jumping activities which they can ill afford, and their health will suffer as a result.

Furthermore, we are dismayed by the potential waste of health care dollars caused by the number of times forms may have to be completed by health care providers. We are committed to the efficient use of the scarce healthcare resources in the province and would rather devote our own time to health care provision instead of repeated form completion.

We call for the following:

- ◆ No Ontario Works client currently receiving the special diet allowance should have to undergo a review before the 12 month period specified in the regulation;
- ◆ No one receiving or applying for the special diet allowance should have to sign a “consent to release medical information” form; the new special diet form provides a space for practitioners to sign certifying that the dietary need arises from a medical condition and this should be sufficient;
- ◆ Photocopied forms should be accepted as they are identical to originals and there is no sound justification to deny benefits to anyone

because of the type of paper a dietary prescription is written on;

We strongly reject the strategy proposed by Toronto Social Services targeting low income families with children for “review” which is clearly discriminatory and mean-spirited; We reject as well the notion that we have not fulfilled our professional obligations with integrity and as such can see no purpose for a third party review of our assessments.

Our clients have profound health risks. We know that despite the best care we can provide, they will suffer serious health problems and premature mortality. We call for an immediate moratorium on the above policy changes which will only create a greater burden of illness in our community. I look forward to an expeditious reply and can be reached by phone at (416) 364 2261 or by email at tara.kiran@utoronto.ca.◆

Dr. Tara Kiran, MD, Regent Park Community Health Centre (for)  
Kathy Hardill, RNEC  
Anne Egger, RNEC  
Dr. Roy Male, MD  
Dr. Miriam Garfinkle, MD  
Dr. Peggy Lathwell, MD  
all of Regent Park CHC  
Dr. Gary Bloch, MD  
Dr. Tomislav Svoboda, MD  
Dr. Monika Dutt, MD  
all of St. Michael’s Hospital Family Medicine  
Liz Polatynski, RN, of Access Alliance Multicultural CHC  
Jason Altenberg, and  
Jane Boudebab, RNEC  
of South Riverdale CHC  
Cathy Crowe, Street Nurse, Atkinson Economic Justice Fellow  
Dr. Mimi Divinsky, MD  
Medical Reform Group

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# CITY OF TORONTO COUNCILLOR MIHEVC RESPONDS TO RENEWED QUERIES: SAME ANSWERS FOR DIFFERENT QUESTIONS

*Councillor Mibevc, Chair of the City of Toronto Committee responsible for the social services portfolio responded to both the provider letter and the MRG letter with the same text:*

Thanks for the email. Further meetings have been held with social services staff. I can advise you the special diet allowance will not be dependent on a 'consent to release medical information' as previously was the case. The following instructions have been given to social services staff:

**Subject: Ontario Works Special Diet Allowance Update - Revised Application Process**

Further to Heather MacVicar's earlier communication to you on August 3, 2005, effective Monday, August 15, 2005, Toronto Social Services will introduce revised procedures for Ontario Works clients requesting Special Diet Allowances.

All requests for Special Diet Allowances will no longer require the

following two documents to be completed/submitted to Social Services staff:

- ◆ Consent to Release Medical Information Form
- ◆ Notice to Physician and/or Registered Nurse Extended Class

All requests for Special Diets Allowances will continue to require the use of a Special Diet Application Form to determine eligibility for the benefit. This specific form is available in all Social Services local offices.

The following four designated health professionals can complete the Special Diet Application Form:

- ◆ Physician
- ◆ registered nurse-extended class
- ◆ registered dietician
- ◆ registered mid-wife

Given the above changes to the procedures, the Special Diet Allowance Requirements - Fast Facts document that was forwarded to you August 3rd is not longer relevant. Social Services will be communicating with the Community Health Organizations regarding this change to the application process.

\*\*\*\*\*

I trust that helps clarify the new process and re-assures you that the city is not overburdening or second-guessing professionals who are being asked to adjudicate as to whether a special diet is required. We are confident that we are acting in accordance with provincial regulations as well. ◆

*Joe Mibevc, Sent: Sunday, August 14, 2005*

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## HAMILTON HEALTH COALITION PLANS FOR PLEBISCITE ON FOR-PROFIT HEALTH CARE (continued)

confidential deals and arrangements, the public is often left picking up the tab for expensive legal disputes when private companies fail to live up to their contracts.

The latest developments are that on May 25 Minister for Public Infrastructure Renewal, David Caplan, released his long-anticipated 5-Year Infrastructure Plan. The full plan is on the ministry website at: [www.pir.gov.on.ca](http://www.pir.gov.on.ca).

The plan calls for:

- 66 hospital projects over 5 years. 30 – 35% (approx. 23) of these are large and complex. The report says, "a significant number of large complex projects will be financed and built using alternative financing and procurement methods" pp. 7. This means that the plan is to finance up to 23 hospitals through private finance mechanisms or P3s.
- the completion of 39 current projects (financing mechanism unclear).

### **Which hospitals are affected?**

Ontario Health Coalition are attempting to get a list of the up to 23 hospitals that are slated for potential private finance mechanisms. As soon as this information is available it will be circulated widely. more potential revenue streams for themselves than are likely in expansion or renovation projects. ◆

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# THE EXPERIENCE OF A LIFETIME

Earlier this year, Steering Committee member Wendy Lai spent one of her final residency rotations at Rankin Inlet in the Territory of Nunavut. She recently spoke with Janet Maber about what she had learned.

I was born in Newfoundland and came to Ottawa with my parents at 13. I did undergraduate work in biochemistry at McGill and was active on social issues at QPIRG. At the time, I thought being a suburban family doctor would have to be pretty boring and I think for a long time I had the idea that I would end up in law.

When it came down to it though, I wasn't all that excited about law, and once I sat down and examined my priorities and my aptitudes, realized that medicine, was at the intersection of being progressive and practical, and made use of the skills and qualifications that I had up to that point (near the end of my undergraduate degree).

What I was surest about was that I wanted to be doing something concrete and meaningful in the way of social justice, but it took some time for me to decide that medicine was a good place to do that.

When I was at McGill I had met Katherine Rouleau who came for an international health conference. She really introduced me to inner city health and issues of power and marginalization and I soon learned that there are a lot of ways to think about dealing with inequality and barriers to care and that many of them are related to social justice.

What Katherine did was turn up in my life at a time when I was envisioning medicine as a way to approach social justice, and prove to me that this kind of medicine did exist— at 410 Sherbourne.

In any case, I did my medical training at the University of Western

Ontario and just completed my residency in family medicine at St. Michael's Hospital in June.

I have had the benefit of two particular mentors while there— Katherine as I have said, and Ahmed Bayoumi. They have taken an interest, encouraged me when necessary, for example, Ahmed introduced me to the Medical Reform Group Steering Committee. I have benefited from their ideas and encouragement, and from the opportunities that they think might interest me.

***JM: Can you tell our readers where you are heading, what recent training and experience have fit you for that?***

Well I think I have now understood myself as a generalist. I love the variety of what I am doing now, dealing with the multitude of “social determinants of health”, some work on HIV, addictions, food and housing issues and the issues of newcomers. And I love the variety of medical problems that I see. I would be bored as a specialist; that's not the kind of brain I have.

***JM: How did you come to go on the rotation to Nunavut?***

Part of the family medicine residency at the University of Toronto is to do a two month rotation in a remote or rural setting. I had many opportunities for Southern Ontario rural links while I was at Western, so the idea of doing another was not that appealing. I also went to Sioux Lookout as a student and learned a lot, but wanted to go some-

where else. I applied to go to Moose Factory where there is a different model of care.

I am interested in the health issues of aboriginal people. I think they have unique challenges, and creative solutions are lacking. However, they were not able to provide supervision because of issues in the community.

At that time, I looked again at Sioux Lookout, but they already had their quota of residents – mainly from McMaster.

I learned about the Northern Medical Unit connected with the University of Manitoba at Winnipeg and called them, explaining my interests and predicament. (U of T had a contact there. They were totally enthusiastic about having residents.)

Although their first priority is in service for patients rather than education of residents, U of T by this time was willing to allow me to go, given my interests. Their service area is northern Manitoba and southern Nunavut.

They were pretty helpful with resources to help me prepare for the trip. Where I was based was Rankin Inlet. This is in Kivalliq region adjacent to Northern Manitoba. It's just east of the North West Territories and south of the Arctic Circle.

Nunavut is very decentralized. We worked from a health centre which directly served about 2,500 people, and were in contact with another 8 communities of perhaps another 5,000 in total. The stations there are mostly run by nurses of very exceptional skill. As needed, and

*(continued on page 21)*



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## THE EXPERIENCE OF A LIFETIME (continued)

weather permitting, we would fly to the other communities to do clinic.

I got to four or five other communities over the two months: all varied in culture and character.

The medical problems vary. There are a few specialists who make regular, more or less monthly visits, like Gynecology, Ear Nose and Throat and the Dentist, but most of the rest of issues will need to be sent to Winnipeg. This is not an easy situation. You can expect that on a good day organizing the flight will mean a minimum of 4 to 5 hours (that's for emergencies) and often 8 or more, by the time the patient is stabilized enough to be moved and the weather cooperates.

Although there is a possibility of bringing patients from the outlying communities to Rankin, more often they will end up going to Winnipeg. (Rankin Inlet will soon open a hospital that will be able to manage inpatients. Right now there are no inpatient services in the region.)

There is no surgeon and no anaesthetist and other resources are very limited. The Region is trying to secure the services of at least six MDs, but so far they manage pretty much with four. There has also been an attempt to attract midwives to the region but so far this has been pretty sporadic. What this means is that most of the most important life events happen away from family, in Winnipeg or Iqaluit.

I am not sure if decisions about care are made that differently, but there are certainly ethical issues around standards of care that need to be considered. These communities are very new—most did not exist at all 20 years ago, and so most of

the older people do remember growing up 'on the land.'

The other thing that might be of interest to people is that there are not really any traditional healers left in the North (unlike southern First Nations communities).

***JM: What did you do in your off-time?***

The place I was in was very beautiful, but mostly very cold at that time of year—February and March. They did have a small gym which I used as much as possible. But otherwise, there were frequent dinner parties and board games. I watched more satellite TV than ever in my life. And I studied—I wrote my certification exams just after I returned.

***JM: Will you go back to Nunavut? What would you do differently, if anything?***

I plan to go this year, but likely not in the dead of winter as the NMU is proposing. I would love to see it when the weather is more hospitable, and there's more to see and do: go out on the land and sea, encounter animals, etc. I'm not sure that I'd take up hunting, though.

Medical work in the north is very interesting. It is all about primary care—because there's no one else, and sending someone out is complicated and expensive—and forces you to have your wits about you. It stretches your clinical skills daily. Extended contact with the south is very recent, and I found myself having to rely on interpreters for both young and old patients.

There is a symbology which is definitely Canadian but originates in the North. I think everyone should

have some exposure. The landscape is stunning, the people fascinating, the arts and crafts and language very much alive. And because contact with the south is relatively recent, this is a time of a lot of social and societal change. There is also a lot of opportunity to help shape health care there, since the population is small, and the government recently established, with a focus on finding Northern solutions.

I was also in a bit of a unique position because, while I am definitely a southerner, I do bear a certain physical resemblance to the Inuit, to the point that sometimes people addressed me in Inuktitut.

***JM: Any other observations you think might be of interest to our members?***

One of the things I think was most interesting is the diversity of settings in which marginalization can be played out. This was clearly not an inner city health setting, and yet many of the forces at play are similar. ♦

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# OUR NOT SO LIBERAL NEW IMMIGRATION POLICY

*We reproduce below copies of letters sent recently to immigration Minister, the Hon. Joe Volpe and we encourage members to forward similar letters on behalf of these two physicians. Dr. Shazia Khalid was raped in the course of her work for the Pakistani Army then forced to flee when her in-laws wanted her dead for staining the family name. Although she has family in Canada, and Canada prides itself on some very innovative human rights policy designed especially to offer succour to victims of sexual violence abroad, her application was refused. The second physician, Dr. Salam Ismael is a young Iraqi who has already spoken on the state of Iraqi health care at many international conferences, and had been invited to do the same in Canada. His application was also denied, apparently on the grounds that he might not return to his country.*

August 3, 2005.

Honourable Joe Volpe, Minister  
Citizenship and Immigration Canada  
365 Laurier Avenue West  
Ottawa, Ontario  
K1A 1L1  
Fax: (613) 992-9791  
Re: Dr. Shazia Khalid

Dear Minister:

I am writing on behalf of the Medical Reform Group of Ontario to urge your government to review the immigration application of Dr. Shazia Khalid, who was brutally raped in Pakistan earlier this year.

We understand that Dr. Shazia has family and friends in Canada and that asylum here would permit her to heal and recover her health in safety.

We urge you to reconsider this unfortunate response to Dr. Shazia's initial application to enter Canada on an urgent basis. ♦

Sincerely,

Dr. Gordon Guyatt,  
For the Medical Reform Group

July 15, 2005.

Honourable Joe Volpe, Minister  
Citizenship and Immigration Canada  
365 Laurier Avenue West  
Ottawa, Ontario  
K1A 1L1  
Fax: (613) 992-9791  
Dr. Salam T. Ismael, File: V050600215

Dear Minister:

I am writing on behalf of the Medical Reform Group of Ontario to seek an explanation for the refusal of our government to facilitate the Canadian speaking tour of Dr. Salam Ismael, general secretary of Doctors for Iraq, an Iraqi NGO which has had considerable experience in monitoring the progress of hostilities there on the human rights of civilians and very particularly of their access to health services.

We understand Dr. Ismael has been told the denial of permission to enter Canada is due to his failure to persuade the officer in the office in Amman, Jordan of his stated reasons for the tour. While we understand and appreciate the need to investigate all visa applicants thoroughly, we are very concerned that such investigations proceed in a way that is fair and completely transparent. Dr. Ismael already has a reputation in many European countries as a compelling and balanced speaker, and we believe that Canadians would benefit by exposure to his presentations and the evidence he would be able to provide on the effects of the war on his compatriots.

We urge you to reconsider this unfortunate response to Dr. Ismael's initial application to enter Canada on an urgent basis so that he can combine the trip to Canada in his current itinerary, and minimize the time he will be away from his home base. ♦

Sincerely,

Dr. Gordon Guyatt,  
For the Medical Reform Group  
cc. Dr. Jane Pritchard, Dr. James Loney  
Christian Peacemaker Teams, Toronto

# OUR APOLOGIES

Please note errata in the last 2 issues of **MEDICAL REFORM**.

We incorrectly identified Issue 133 as Volume 25, No. 1,

when it should have been Volume 24, No. 4, and Issue 134 as Volume 25, No. 2, when it should have been Volume 25, No. 1. Our apologies for any inconvenience.

This Issue 135, is correctly identified as Volume 25, No.2.

## MRG MEMBERSHIP APPLICATION

I would like to  become a member  renew my support for the work of the Medical Reform Group

### Membership Fees

- \$245 Supporting Member Physician  
Affiliate (out of province) physician
- \$60 Intern / Resident / Retired / Part-time Organization  
Newsletter Subscriber  
E-Newsletter Subscriber
- Free Medical Student /  
Medical Research Student

Please specify membership category:

\_\_\_\_\_

Please specify areas of interest and expertise:

\_\_\_\_\_

\_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
Province \_\_\_\_\_  
Telephone \_\_\_\_\_  
Fax \_\_\_\_\_  
E-mail \_\_\_\_\_

Please charge my MasterCard/VISA in the amount \$ \_\_\_\_\_. My credit card account number is: \_\_\_\_\_  
Name of Card holder: \_\_\_\_\_  
Expiry Date: \_\_\_\_\_

Mailing Address:  
Medical Reform Group  
Box 40074  
Toronto, ON, M6B 4K4

If you prefer, you may pay your membership fees and supporting contributions through our monthly payment option by completing the following authorization and enclosing a black cheque, marked "VOID" from your appropriate chequing account. I authorize my financial institution to make the following electronic payments directly from my account:  
The amount of \$ \_\_\_\_ on the first day of each month, beginning \_\_\_\_\_, 20\_\_.  
Please credit the payments to the Alterna Savings and Credit Union account (No. 1148590) of the Medical Reform Group. I understand that these electronic payments will continue until I give notice in writing to the Payee to stop doing so; that I must notify the Payee in writing of any changes to the information in the authorization; and that I must notify the Payee within 90 days of any error in the electronic payment.

\_\_\_\_\_

Account holder's name (print)

\_\_\_\_\_

Account holder's signature

\_\_\_\_\_

Date

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# MRG JOINS CANADIAN WOMEN'S HEALTH NETWORK TO IMPROVE ACCESS TO EMERGENCY CONTRACEPTION: UPDATE ON PLAN B

Rosana Pellizzari

The Canadian Women's Health Network is asking individuals and organizations to add their names to a brief being prepared for the National Drug Scheduling Advisory Committee (NDSAC). Scheduling changes made to the National Drug Scheduling System by NDSAC, a committee of the National Association of Pharmacy Regulatory Authorities (NAPRA) are adopted immediately in Ontario. NAPRA is an association that represents the registrars of the provincial colleges of pharmacy across Canada. It is being lobbied to change the current behind the counter status of Plan B to make it available for sale in any retail outlet.

In April 2005, when Plan B was removed from Schedule F of the Food and Drugs Act, NDSAC acted immediately to classify it as a Schedule II drug, making it a behind-the-counter

product with access controlled by pharmacists.

As already described in the last issue of **MEDICAL REFORM**, this behind-the-counter status has resulted in unnecessary restrictions, increased costs, and compromised privacy for potential users. This situation is even worse in small rural communities, where drug stores may have more limited hours of operation, and pharmacists may be family friends. In a growing number of countries, emergency contraception is being offered over the counter. The drug is safe to use, will not affect a pregnancy or harm a fetus if taken inadvertently by a woman already pregnant, and is easy to use since the package contains only two pills and the dosage is identical for all women.

In addition to writing to the Canadian Pharmacists Association to ex-

press its concern over the proposed counselling fee and collection of personal and identifying information, the MRG has added its name to the growing list of supporters calling on NDSAC to reconsider and revise its position. Members are encouraged to review the CWHN's call to action paper, available at [www.cwhn.ca](http://www.cwhn.ca), and to consider adding their names to the brief.

In August, the Perth County Board of Health endorsed the call to make Plan B an "off-schedule" product so that women who require emergency contraception will be able to purchase the product, at lower cost, from a variety of sources. The Board of Health is also calling on the Association of Local Public Health Agencies to take similar action so that unintentional pregnancies can be prevented. ♦

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**The Medical Reform Group  
Box 40074, RPO Marlee  
Toronto, Ontario M6B 4K4**

*Please visit and comment on our web-site at <http://www.hwcn.org/link/mrg>  
Please also make a note of our current contact information as follows:  
(416) 787-5246 [telephone]; (416) 352-1454 [fax]; [medicalreform@sympatico.ca](mailto:medicalreform@sympatico.ca) [e-mail]*