
Medical Reform

Newsletter of the Medical Reform Group

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ONTARIO BUDGET 2006—NO RELIEF FOR THE POOREST DESPITE IMPROVED REVENUE PICTURE

Janet Maher

The third McGuinty Budget in as many years was a great disappointment for many Ontario advocates. Despite an excess of revenue of \$3 billion, mainly additional tax revenue which was largely a result of a better than expected economic indicators, as well as less than budgeted to debt servicing, new measures were few. Indeed many were, in the words of economist Hugh Mackenzie, recycled—re-announcements of commitments already made earlier.

Highlights

While no new taxes or tax increases were announced, the small (0.15 per cent) reduction in capital tax will have significant implications in the coming years particularly for the financial services sector.

The largest single item in the 2006 Ontario budget was Move Ontario, a commitment of \$1.2 billion to address infrastructure needs on urban transit, roads and bridges. Health care was the beneficiary of a further \$1.9 billion, nominally to be dedicated to increasing the number of family health teams and decreasing waiting times for a number of designated procedures.

About 10 per cent of the additional billion dollars projected in increased spending will fund insulin pumps for some 6,500 juvenile diabetics, and support the expansion of provincial newborn and breast cancer screening programs. The other 90 per cent, just under a billion, has been designated for all other purposes, including education, post secondary education and a two per cent increase in welfare rates.

The infrastructure investments will have important short and long term benefits. In addition to jobs in construction and related sectors,

Move Ontario should also mean that we can look forward to fewer cars and parking lots—and the potential of real benefits for the environment in the context of what is essentially a federal withdrawal from Kyoto.

At the same time, the McGuinty government persists in supporting its Alternative Funding and Procurement (AFP) strategy, a variant on public-private partnerships which seems destined to result in more expensive infrastructure renewal, encumbered by partnership deals to ensure 'adequate' return on investment for the private partners.

The additional commitments to the health care sector have the potential to ease some of the bottlenecks which are frequently the target of media stories. However, most will depend for their effectiveness on more assertive intervention by the Minister to ensure that add funding is used in the words of former commissioner Roy Romanow to "buy change"—that is, spent cost-effectively to implement strategies which make the best use of available resources both in prevention and acute care.

While the designation of some priority procedures is undoubtedly a comfort to those Ontarians afflicted

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June 24, 2006**

Please visit our website at: <http://www.bvncn.org/link/mrg>

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Medical Reform

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Editorial committee this issue: Norman Kalant, 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 care is provided.

ONTARIO BUDGET 2006—NO RELIEF FOR THE POOREST (continued)

with priority ailments, where this is done by reallocating within the health budget, the result can be an erosion of the principle of access which is one of the founding principles of Medicare.

First reading of Bill 102, Minister Smitherman's prescription for reining in provincial drug spending, suggests that there is the potential to improve the current situation in which the growth of prescription drug costs threatens not only the provincial treasury but also the financial well-being of families facing excessive drug expenses [see update, below, for more information on the MRG response to Bill 102].

Few social advocates view the government's response to the poorest Ontarians as anything other than a betrayal of McGuinty's fulsome promises in 2003 to restore the National Child Benefit clawback for welfare recipients. As noted by Globe columnist Murray Campbell on March 28th, "it would have taken only 7 per cent of Ontario's \$3 billion surplus for Premier McGuinty to keep his promise to poor families that he would end the clawback of the National Child Benefit Supplement. \$220 million—that is how much the Ontario government takes away from parents and children on social assistance every year. That translates into \$1,400 a year per child for parents who are struggling to pay the rent and feed their children on as little as \$987 a month. \$1,400 each year can make the difference between using food banks and having the money for nutritious food; between having to sit out school and sports activities and having the opportunity to participate in the school and community life."

"It would also be a huge step towards telling those parents and children that they are just as valued as the families who get to keep this anti-poverty benefit. Other priorities like transit are important, but what kind of government chooses to ignore the present and future well-being of over 160,000 children and their families. We should all be looking at our shoes in shame" [see next page for a copy of the letter sent to Finance Minister Duncan].

Instead of the monotone to their federal counterparts on the fiscal imbalance, 2006 would have been the perfect opportunity for our provincial leaders to pay some attention to addressing the fiscal imbalance to which the provincial government has subjected particularly the larger municipalities by continuing to require them to use property tax revenues to support emergency welfare and child care.

The release in early May of the Task Force Report of the Toronto City Summit Alliance and St. Christopher House on Modernizing Income Security for Working Age Adults is a compilation of discussions of some 60 community leaders from all sectors in Toronto. While there was not complete consensus among the leaders, what remains notable about the document is that even the majority report calls both federal and provincial governments to task for their short-sighted approaches to income security for the most vulnerable, with recommendations to step up to the plate with better supports for health benefits for those in marginal employment and moving with a little more purpose and dispatch to increase minimum wage and other employment supports. ♦

ADVOCATES WANT PROVINCE TO ADDRESS THE SOCIAL DEFICIT TOO

On March 29, 2006, about a week after the release of the 2006 Budget, the Medical Reform Group joined many other advocates to urge the Ontario Finance Minister to make good on their commitment to return the National Child Benefit Supplement to families of social assistance recipients.

We heard your comment on March 27th indicating an interest in ending the provincial government's claw back of the National Child Benefit Supplement and am writing to urge you to take decisive action and follow through on this election promise.

In follow-up interviews to the March 23rd Ontario budget you mentioned you would have liked to have done more to support the most vulnerable members of our society – those on social assistance.

Ending the clawback would be one immediate way that you as Finance Minister could have an immediate impact on lessening the levels of hunger and hardship experienced by families on social assistance who have experienced a 40 per cent decline in real incomes over the past ten years.

The most common reasons for families to turn to social assistance are: health problems, loss of a spouse, and unemployment. 71 per cent of the families on social assistance are led by lone mothers.

Ending the clawback would help reduce hunger for vulnerable families. In the GTA alone, studies by the Daily Bread Food Bank show that almost 14,000 children would no longer need to use food banks if the Province did not claw back the NCBS from their social assistance cheques. Across Ontario children represent 43 per cent of people using food banks.

The 2006 Ontario Budget identified \$2.2 billion higher than expected revenues. Revenues are forecast to continue increasing from \$85.7 billion in 2006-07 to \$90.3 billion in 2007-08. The Liberal Government cannot keep arguing there are insufficient funds to fund the \$220million per year needed to end the clawback and maintain the programs on which those funds are now spent. Families on social assistance deserve to be able to raise their families in dignity.

The 2006 budget took significant steps to address the 'transportation deficit'. I urge you as Minister of Finance to show equal determination and creativity to address the 'social deficit' and the fact that one in every six children in Ontario live below the poverty line. Ending the provincial claw back of the National Child Benefit Supplement would be a significant step. ♦

THE CMA SUPPORTS PUBLIC HEALTH CARE SYSTEM — OR DOES IT?

Norman Kalant

The Supreme Court decision in the "Chaoulli Case" made everyone acutely aware of the problem of waiting lists and delays in obtaining certain types of medical service, even though they are nominally available in the public healthcare system.

The provincial governments in particular were seized with the need to establish limits to waiting times for specific elective surgeries, and to establish procedures for obtaining and paying for the delayed therapies at

sites outside the province if necessary. Like an ever recurring echo from past Medicare "crises", the development of a parallel private healthcare system was seen by some as the answer to this problem, arguing that this would remove the pressure from the public system. The CMA decided to take the opportunity to prepare a position paper on the relationship between public and private health care.

BACKGROUND

1. Previous CMA discussion papers.

Two earlier discussion papers are of interest as possible indicators of the CMA approach. The first (Looking At The Future Of Health, Health Care And Medicine, 2000), describes four hypothetical visions of the future of Medicare, based on different economic assumptions. The second (In Search Of Sustainability, 2001) presents four hypothetical situations, each based on a different assumption

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THE CMA SUPPORTS PUBLIC HEALTH CARE SYSTEM — OR DOES IT? (continued)

regarding expenditures, aging of the population, or improved efficiency.

There was no serious attempt to evaluate the validity of the various assumptions (some of which were not mutually exclusive), but a small number of selected individuals were asked their opinions of the likelihood or probability of each of the visions.

No conclusions were drawn from this exercise.

2. CMA General Council Meeting, August 2005.

i) A motion brought by the Canadian Association of Internes and Residents “that the CMA supports access to healthcare based on need, not ability to pay, and that the CMA calls on governments and key stakeholders to work with physicians to ensure that instead of permitting the development of a parallel private healthcare insurance system as a solution to unreasonably lengthy wait lists, Canada maintains a strong, vibrant, publicly funded healthcare system that is capable of meeting the healthcare needs of all Canadians.”

This motion was divided into 2 parts which were voted on separately:

That the CMA endorses the principle that access to medical care must be based on need and not ability to pay.” Passed, 96 per cent for, 3 per cent against.

“That the CMA calls on governments and key stakeholders to work with physicians to ensure that instead of permitting the development of a parallel private healthcare insurance system as a solution to unreasonably lengthy wait lists, Canada maintains a strong, vibrant, publicly funded

healthcare system that is capable of meeting the healthcare needs of all Canadians. Failed, 67 per cent against, 33 per cent for.

ii) Motion “that the CMA, working closely with its divisions and affiliates develop a discussion paper with policy principles that will define and guide the relationship between the public and private sectors in the delivery and funding of healthcare in Canada, which will be presented to the Board within 6 months”. Passed

iii) Motion “the CMA supports the principle that when timely access to care cannot be provided in the public health care system, the patient should be able to utilize private health insurance to reimburse the cost of care obtained in the private sector.” Passed

iv) Resolution calling on governments to enact legislation by 31 March 2007 to provide public funding at the patient’s home province/territory rates, including travel and accommodation costs, to enable patients to seek treatment where and as available when benchmark waiting times are exceeded. Referred to the Board of the CMA.

Several other related resolutions were passed.

3. Implementation of Motion 2 ii). An Ad Hoc Task Force on the Public-Private Interface was struck. The work of this group has led to a “discussion paper” to be finalized sometime in the late spring. At the same time, President Ruth Collins-Nakai asked the membership for comments on the resolutions passed by the Gen-

eral Council. The responses were analyzed by an independent consultant and the results published. In brief, 32 per cent favoured a completely public system with no private aspects, 30 per cent favoured a mostly public system with private care available only under specific conditions, 23 per cent favoured parallel public and private systems, and 4 per cent favoured a fully private system with no public aspects.

FUTURE DEVELOPMENTS

1. Likely emphasis of CMA papers

Access: The main focus of the CMA message has thus far been “access,” a theme which in the post-Chaoulli world seems to have become synonymous with the introduction of private insurance rather than retaining its original association with “access based on need”. Undoubtedly the financial “unsustainability” of the public system will be the justification for any privatization advocated in the Discussion paper.

Care guarantees and the “safety valve”: In its submission to the Romanow and Kirby Commissions, the CMA proposed a “safety valve” whereby patients who waited longer than the guaranteed (i.e., maximum) time would have some recourse, either through “gap insurance” or through public funding. More recently Bill Tholl and Ruth Collins-Nakai have discussed a “Canada Health Access Fund” composed of public dollars that could be used to get faster access to care for such patients. Many see this fund as one that could be used to pay for patients to get care in the private sector within Canada if the public system doesn’t meet the

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THE CMA SUPPORTS PUBLIC HEALTH CARE SYSTEM — OR DOES IT? (continued)

benchmark...in essence public subsidy of a second tier.

Privatization of non-clinical services: The CMA has already endorsed P3s and contracting out of all kinds of services. They pay lip service to ensuring high quality of care, but proponents of this goal appear not to recognize that governments have no capacity or desire to judge quality of care in the public system which they control; they will have even less in a private system over which they have no control.

2. Process. The papers will be drafted by CMA staff and reviewed by the elected members of the working group, under the co-chairmanship of Bill Tholl, Marshall Dahl, Suzanne Strasberg and Robert Hollinshead. Three of the four chairpersons have previously expressed their support for increased privatization. In addition to this array, the President-elect who will serve as President for 2007-8, is Dr. Brian Day, founder of a for-profit clinic in B.C.

The evidence is clear that the cost of care is higher and the quality of care is lower in for-profit institutions than in not-for-profit institutions. Very recent studies in the US show that physician-owned specialty hospitals (such as that established by Dr. Day) in comparison to publicly owned hospitals appear to have lower costs per patient because they engage in "cherry-picking" the healthier patients. As a result of these findings Congress put a moratorium on further development of such hospitals. When presented with these facts, the response is usually to ignore them.

3. Outcome: Despite the strong support for the public healthcare system and the weak support for a private system shown by the survey of the CMA membership, the Board and the President-elect are in a position to ignore the membership and endorse a Discussion paper that is strongly pro-privatization.

4. Speaking Out: Doctors who feel strongly that the CMA's initial position on the public-private debate is inadequate or even dangerous need to speak out.

Private insurance clearly under consideration, something which would deeply affect access to care for most Canadians except for a small wealthy minority. Beyond this, the total disregard for the evidence around private delivery will prove problematic down the road.

The evidence is clear that private delivery is more expensive and leads to worse quality of care, yet the numbers of private hospitals and clinics across Canada continues to increase, many of which have physician owners and stakeholders. Further, the subcontracting out of non-clinical services and P3 hospitals which represent enormous waste of public money with a total lack of accountability to the public bodes ill for the future of our system. The CMA has been silent on these issues at best, and in many instances CMA representatives have spoken in favour of these phenomena.

The MRG will continue to fight on all these fronts to protect access to care for Canadian patients, including to the CMA. We hope you will use every opportunity to make your voice heard! ♦

CANADIAN DOCTORS FOR MEDICARE

Karen Trollope Kumar

Canadian Doctors for Medicare is an organization that has recently formed to provide a strong voice for physicians who oppose the trend toward health care that is privately funded.

We believe that access to health care should be based on need rather than ability to pay, and that physicians have a responsibility to advocate for equitable access to health care for all Canadians, not just for the privileged.

We are committed to supporting and strengthening Canada's publicly funded healthcare system. Our goal is to provide a voice for the thousands of physicians across Canada who believe that Medicare remains the best way to provide high quality health care for all our patients.

Medicare is under threat as never before, as privatization within Canada's health care system expands at an unprecedented rate. Last year, in a decision that applies specifically to Quebec, the Supreme Court struck down the law banning private health insurance for essential care, citing that people have a right to buy private health insurance to cover medically necessary procedures in situations where wait times in the public system were unacceptably long.

In Quebec, a decade of unprecedented cuts in health care spending had exacerbated the problem of wait times significantly. While length of waiting lists is clearly of great public concern across Canada, the solutions to unacceptably long wait times are not to make prompt care the reserve of those who can pay.

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CANADIAN DOCTORS FOR MEDICARE (continued)

In the debate about privately funded health care, several fallacies resurface again and again. It is often said that more funding from the private sector will increase the sustainability of the health care system.

Yet studies of countries that move towards increased private spending on health care show that overall costs spiral upward. In fact, in terms of percent of GDP spent on health, Canada is in the middle of the pack among industrialized nations. The major reason that we spend approximately half of what the U.S. spends per capita on health care are the enormous administrative efficiencies that come from having a single payer system.

Another myth is that opening up a "second tier" would decrease waits in the public system. Yet here the fallacy lies in the issue of human resources. Private clinics need skilled professionals—doctors, technicians and nurses. When these highly skilled people move to the private sector, there

is a serious drain of human resources out of the public system. Experience in a number of jurisdictions – Britain, Australia, New Zealand, Alberta and Manitoba among them – suggest that while wait times are minimal for those who pay privately, the opening of a second tier actually increases wait time among the remainder.

There are solutions to unacceptably long wait times for medically necessary services. For example, cardiac care treatment wait times have been improved significantly in Ontario, as have wait times for hip and knee services in Alberta. This has been achieved within the publicly funded system, by better coordination of existing resources as well as new funding.

A commitment to a publicly funded health care is an important Canadian value. This was highlighted recently in Alberta, where the Klein government had to back away from the "Third Way" proposal that would introduce a second tier into the pro-

vincial health care system. The medical profession, however, has been giving mixed messages to the Canadian public on the privatization issue. Brian Day, the president-elect of the CMA, is strongly pro-privatization. If he is elected in August, this will give a powerful message to the Canadian public that doctors support the move toward increasing privatization.

Through **Canadian Doctors for Medicare**, physicians across Canada will be able to advocate for a strong publicly funded health care system, while resisting the trend towards increasing privatization. Non-physicians are welcome to join the organization as Friends.

If you agree with these fundamental principles, please join us at www.canadiandoctorsformedicare.ca, and pass the word about this organization along to your colleagues. ♦

STUDENT PETITION ATTRACTS 1,000 SIGNERS

Janet Maher, with files

As reported last issue, Canadian medical students have also expressed their concern over the implications of the CMA debate at the 2005 annual meeting for the future of Medicare.

University of Toronto graduating medical student Andrew Pinto has led the effort to educate his colleagues across the country and, earlier this year, began to circulate a petition which:

- ♦ reaffirms their support for the Canada Health Act principles of universality, comprehensiveness, accessibility, portability and public

administration;

- ♦ calls on the CMA and its members--their mentors, teachers and supervisors--to support public medicine; and

- ♦ expresses their disagreement with the motion passed at the 2005 CMA Annual Meeting, stating that patients who can't get timely access to care should be allowed to rely on private health insurance and private sector health services, rather than strengthening the public health care system.

Over the winter, over a thousand students across the country have

signed on, and the group is now working on a strategy for seeking an opportunity to address the board of the CMA to present the petition in the coming weeks.

As of the end of this academic year, the students have identified links across the country, and come together to work on a range of educational projects on access to and quality of health care in Canada and worldwide. ♦

SAY IT AGAIN—NO TO P3S

On March 17, 2006, 75 Ontario physicians and medical students signed an Open Letter to Premier McGuinty, seeking accountability on his commitment to public ownership of publicly funded health care facilities.

Funding for hospital redevelopment in Ontario should give the best value for citizens' tax dollars. Hospitals should be under democratic governance and operated according to the principles of the Canada Health Act.

The funding mechanism promoted by the government, 'Alternative Funding and Procurement', presents several problems. AFP is a version of Private Public Partnership, or P3, in which for-profit consortia take over financing, construction, facility management, maintenance and some hospital services for long term deals stretching up to 40 years. They often seek additional revenue through commercial land deals on the public hospital lands, and service charges or user fees for patients and their visitors.

We are deeply concerned about the government's plans to impose P3s on our hospitals. P3s have proved to cost more and to result in compromised services. In the UK, the facilities funded through P3s have 'almost invariably provided less capacity than those they were intended to replace.' (R Atun, M McKee *BMJ* 2005;331;792-793)

Information provided to the public about P3s is frequently inaccurate. The December 2005 newsletter of Hamilton Health Sciences says about the hospital expansion and redevelopment projects in the city that 'the private sector will take on the task of designing and building as well as the financial risks of ensuring that the project comes in on time and on budget. Hospitals will remain publicly owned, controlled and accountable.

The government's decision to use the AFP approach to financing means we will be able to offer state-of-the-art programs and services for our patients in great new facilities much sooner than would be possible using the traditional government financing approach.'

However, of the 4 projects, the 3 larger ones will in all likelihood involve not only construction but also profit-generating facility management, maintenance and services. As for protection against financial risk, in the UK, P3 hospital development has frequently greatly exceeded budgets and timelines. While the public may have title, in the UK, control has been elusive as it has commonly been difficult and expensive to bring about needed structural and service changes. And there is no basis for claiming that P3s achieve development 'sooner'.

The solution is for hospital redevelopment to be funded publicly. Governments can obtain much more favourable borrowing terms than can the private sector. The public will pay for our hospitals either way. But with public funding, we avoid the higher costs of P3s and keep hospital management, property and services in public hands. And we stop the growth of a for-profit health industry that has an interest in two tier healthcare from which they can take profit, further increasing the cost of health care.

As Roy Romanow, head of the Commission on the Future of Health Care in Canada said in his report: 'I have carefully explored the experiences of other jurisdictions with co-payment models and with public-private partnerships and have found these lacking. There is no evi-

dence that these solutions will deliver better or cheaper care, or improve access (except, perhaps, for those who can afford to pay for care out of their own pockets).

More to the point, the principles on which these solutions rest cannot be reconciled with the values at the heart of Medicare or with the tenets of the Canada Health Act that Canadians overwhelmingly support.'

We call on the government to act in the public interest and to use citizens' dollars responsibly. Hospital construction and services must be publicly funded and hospitals must remain fully publicly managed and serviced. ♦

MDS WANT TO KEEP HOSPITALS PUBLIC

On March 20, 2006, Gordon Guyatt wrote the Toronto Star about their coverage of the Open Letter as follows:

As one of the MD signatories of the letter to Premier Dalton McGuinty, I wish to point out an error.

It was not written on behalf of the "left-leaning Ontario Health Coalition." The effort on our part is being done collaboratively with the Medical Reform Group and the Ontario Health Coalition.

It is our view that incurring the additional costs that are associated with the Alternative Funding and Procurement mechanism — in the form of higher rates of borrowing, profit-taking and management fees — is bad stewardship of public money. It is not a matter of left or right. ♦

MEDICAL WRITERS THREATEN BOYCOTT OF CMA JOURNAL--AUTHORS WANT EDITORS' DISMISSALS EXPLAINED

Authors of a popular series of articles published in the Canadian Medical Association Journal have threatened to withhold pending instalments unless the journal's owners clarify why the CMAJ's editor and senior deputy editor were fired.

Dr. John Hoey and his senior deputy, Anne Marie Todkill, were dismissed Feb. 20 in what the journal's owner, the Canadian Medical Association, has described as a need to revitalize the editorial leadership but which critics say was the result of a battle over editorial independence.

"Unfortunately, our confidence in the CMAJ as a journal that ensures editorial autonomy has been shaken," Dr. Gordon Guyatt of McMaster University said in a letter to CMA president Dr. Ruth Collins-Nakai and acting journal editor Dr. Noni MacDonald on behalf of the group of authors.

"Unless it is restored, we feel we cannot submit the new set of articles to the CMAJ, and will be compelled to submit elsewhere. Restoring our confidence will require an honest, straightforward explanation for the firing of Drs. Hoey and Todkill." Attempts to reach Dr. Collins-Nakai and Dr. MacDonald for comment were unsuccessful yesterday.

Dr. Guyatt and 11 colleagues — leading academic physicians from Canada and the United States — have been working on a second series of articles on evidence-based medicine.

The first batch of five articles, published in 2004 and 2005, were among the most popular downloads

from the journal's on-line archive, they noted.

The series was designed to help clinicians interpret and put into practice emerging medical evidence published in peer-reviewed journals. The version in the print edition of the journal was aimed at practising doctors while an on-line version was aimed at those teaching in medical schools.

Dr. Peter Wyer, of Columbia University Medical Center in New York, said the aim of the series was to make doctors "evidence literate . . . so they can read and understand what's being reported," he said from Westchester, N.Y.

Dr. Wyer said the group is not comfortable submitting new work to the journal at this point.

"We're very troubled by the situation there. And if it came down to a choice between publishing in a journal that lacked independence, I think we all agree that that is just not acceptable. It would neither be good for the series nor ultimately the journal."

Critics of the firings have argued that under Drs. Hoey and Todkill, the journal's impact factor — an industry measure of its importance — soared.

And just last week it was announced the journal had received its second nomination for a Michener Award for public service journalism for an article on the way pharmacists were handling sales of the emergency contraceptive Plan B. ♦

First published in the Globe and Mail April 5, 2006 by Canadian Press reporter Helen Branswell

MRG VS BIG PHARMA

Ontario's Bill 102

Janet Maher

Not long after the tabling of the 2006 Ontario Budget, Health Minister George Smitherman introduced his Transparent Drug System for Patients Act, 2006 as Bill 102 on April 14th, 2006.

At press time, the bill has received second reading, and has been sent to the Social Policy Committee of the Legislature for public hearings. The MRG has requested an opportunity to intervene and is in the process of preparing a brief.

We spoke recently to member Joel Lexchin for his evaluation of the Bill, and summarize here some of his preliminary observations.

Lexchin notes, as with most things, the impact of the bill will depend on what the details look like. Nonetheless, he expects that many of the provisions have the potential to address some of the most pressing issues in public funding of prescription drugs in Ontario.

Lexchin notes several provisions which will begin to rein in costs to the provincially funded Ontario Drug Benefit and Trillium Drug Programs. He asserts that the regulation of discounts from generic companies to pharmacies and plans to lower prices for generics is promising. However, he has some concerns about an amendment which changes the wording for generic equivalence from "same" to "similar," which he believes can open the door to reference based pricing, despite the fact that the government says that it is not introducing reference based pricing. He suggests that while in theory, paying pharmacists for advice is a good idea, it hasn't worked in Quebec.

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MRG VS BIG PHARMA (continued)

Bill 102 (continued)

His assessment on conditional approval for new drugs will depend greatly on the conditions and subsequent evaluation roll out. He has similar reservations about the proposal to allow drug companies to raise prices of products on the formulary under certain conditions. Without clarity on what conditions this may prove meaningless. Moreover, it will be interesting to see if this is accompanied by provisions for lowering prices under certain other conditions.

The point of instituting more research on value for drugs is also not clear. As he notes, \$5 million in this context is not really a lot of money. As well, without specifics on the much-vaunted concept of transparency, it is difficult to evaluate the potential impact of this provision.

Finally, the naming of a 'drug czar' and appointment of two citizen representatives on the Drug Quality Therapeutics Committee (or whatever the renamed body is) can be a double-edged sword. Provided that these people are independent of the pharmaceutical industry and patient groups funded by the industry, and operate within clearly defined regulations, both measures have the potential to speed up the approval process and the degree of fairness expected in a part of health system which continues to account for an increasing proportion of our health budget.

The debate over the bill may provide some information to answer some of these questions and Lexchin will work with the Steering Committee over the next weeks and months to review the detailed language of the bill and develop a brief for the hearings. Stay tuned. ♦

Direct to Consumer Advertising—an infringement of Charter Rights?

Janet Maher

Early in 2006 came the news that Canwest Global Media has launched a charter challenge on the current federal regulation of Direct to Consumer (Drug) Advertising [DTCA], in a case which many observers expect will reach the Supreme Court of Canada.

The law firm of Sack, Goldblatt Mitchell, which has acted on behalf of many social advocates, is assessing the merit of seeking leave as an intervenor in the case and steering committee member Steven Barrett will keep us informed of that application.

In the meantime, member Joel Lexchin reported in mid-March on his preliminary discussions of the case with one of the lawyers who will be handling the DTCA case for the government. Here is some of what he learned.

It appears that the government is taking this case seriously. One of their lawyers arguing this case is a constitutional expert who previously argued the same-sex marriage case. She is encouraging groups to seek intervenor status but warns that activist groups would likely have more trouble getting status than groups that are seen as more neutral, for example, the Canadian Medical Association. Her point is that intervenors are seen as people who are aids to the court and therefore should be there to offer advice to the court. The decision about who gets intervenor status will be up to the court.

Most of the case will be paper based, that is, experts will swear out statements and be cross-exam-

ined by the other side and then the transcripts of all of this will go to the court once the case is heard. The government side is looking for people who have both academic and experiential expertise in this area. Joel's informant stated that the courts will be looking for academic degrees that match up with the expert knowledge people will be offering. Therefore, they may not use anyone from New Zealand, since the perception is that people like Les Toop who did the large physician survey on DTCA in New Zealand does not have academic expertise in this area.

According to Lexchin's informant, the main hurdle with respect to this case will be to prove that a total ban on DTCA (that is, a ban on mentioning the name of the drug and its use together) is necessary and that consumer protection cannot be achieved with lesser measures. (They did not talk directly about what Health Canada currently allows and whether or not that is acceptable. However, in Joel's opinion, if the government feels that its argument is weak, then it may argue that it currently allows some limited DTCA and therefore a further loosening of the regulations is not necessary.)

The federal lawyer expressed the opinion that the argument that CanWest Global is currently using, that the ban on DTCA deprives them of the opportunity to make money, is not nearly as strong as the argument that drug companies would make—that DTCA provides necessary information to consumers and therefore leads to better health. ♦

NEGLECTED DISEASE RESEARCH AND DEVELOPMENT

In early May, 2006, the MRG received a request from a group of medical students from the McGill International Health Initiative, proposing a Canada-wide advocacy campaign in support of a crucial resolution concerning Global health justice.

Under the present framework of drug development and delivery, treatments for diseases that affect the world's poorest get the least funding. There is little profit to be made in finding affordable treatments for these diseases.

A resolution to be presented at World Health Assembly at the end of May 2006 aims to correct this unacceptable situation. Entitled "Global Framework on essential health research and development", the mandate of this global framework will be to create a Working Group of

interested Member States to examine incentives to encourage greater, more sustainable investment in medicines and other products specifically for diseases that disproportionately affect developing countries. The goal of the McGill International Health Initiative is to convince the Canadian government to take a leadership role in support of this resolution.

On May 9, 2006, the Medical Reform Group sent the following letter to Ian Shugart, Senior Assistant Deputy Minister at Health Canada as well as to the federal health minister, the Hon. Tony Clement. Members are encouraged to send similar messages.

Using the patent system to finance research for treatments of diseases occurring mainly in developing countries has been largely unsuccessful because, regardless

of the prevalence of the problem, most people in these countries are unable to afford treatment. At the upcoming World Health Assembly Kenya and Brazil will be sponsoring a resolution calling on the Director-General to establish a working group of interested Member States to consider proposals to establish a global framework for supporting needs-driven research, consistent with appropriate public interest issues.

The Romanow Commission report emphasized the need for Canada to align its long history of the support of human rights with its foreign policy regarding health issues. One way for Canada to demonstrate leadership in this area would be for it to publicly announce its strong support for the resolution. ♦

EMERGENCY CONTRACEPTION UPDATE

On April 16, 2006, we received the following note from Anne Rochon Ford and Madeline Boscoe of the Women and Health Protection Group

Thanks to all of you for your endorsement of the brief we submitted to the National Association of Pharmacy Regulatory Authorities (NAPRA) in early March regarding the question of expanding access to Plan B (levonorgestral).

As you know, we have asked that NAPRA formally request the National Drug Scheduling Advisory Committee (NDSAC) to consider this proposal to have Plan B available off-schedule, i.e. without pharmacist intervention and in unrestricted venues.

The brief was reviewed by the Executive of NAPRA in late March, and they have passed the request to the full NAPRA board who are scheduled to meet on April 23. We

therefore hope to know by the week of April 24 whether NDSAC will be asked by NAPRA to review this proposal. We will keep you posted on what we hear about that.

In the meantime, we have two requests to make of you. First, if the proposal goes to NDSAC, we will likely need to provide further defence for our position that ECP is safe to sell without pharmacist intervention and hope to be able to provide substantiation from other countries. We have a small amount of information about the situation in other jurisdictions, but if any of you have access to information, studies or contacts in other countries where ECP is available in unrestricted venues, we would like to know about it.

Please send any information you have to Anne Rochon Ford (annerf@sympatico.ca) and Madeline Boscoe (ed@cwhn.ca).

Secondly, on the issue of getting help from the media for our case, we have not yet called upon the media as we would like to see first how this will play out with NAPRA and NDSAC. We do, however, anticipate at some point in the near future that we will want to do a press release about what is happening (particularly if we need to put pressure on either organization). And we do periodically get calls from the media wanting to cover this issue. (It has been particularly "hot" because of the role a story about ECP played in the current state

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NATIONAL PHARMACARE STRATEGY

Janet Maher, with files

The Canadian Health Coalition paper, **More for Less: a National Pharmaceutical Strategy**, was launched publicly on February 22nd, 2006 to a media and public eager for realistic approaches to national pharmacare.

In addition to the policy paper, the Coalition has made this one of its key campaigns for the coming year and has available electronically a full kit of materials to support a lobby of federal, provincial, and territorial politicians and members of the Task Force on the National Pharmaceutical Strategy (NPS).

The kit includes fact sheets, a drug index, description of the various public drug plans, as well as a one page briefing note with the Coalition set of demands

EMERGENCY CONTRA-CEPTION UPDATE (continued)

of affairs at the CMAJ.) With regard to any future work with the media, it would be very helpful for us to know if any of you would be willing to talk to journalists who call, or if we might include you as contacts on any upcoming press releases. We are strong believers that the public should see a wide range of people concerned about this issue, not just one or two of us the media happen to have on their call list for this issue.

If you would be willing to make your name and coordinates available for media work, please contact us as above. ♦

Background

The National Pharmaceutical Strategy was agreed to in the September 2004 First Ministers Health Accord. The Health Ministers have also agreed to public consultations and a report by June 2006. There was a limited consultation on drug safety issues in September, but as yet no other consultation and no announcement on a process.

The Health Council of Canada issued its second annual report at the end of January and reported the progress on the NPS as: “*progress is unknown*”. This appears to be due to three main factors: i) the F/P/T process is secret and excessively bureaucratic; ii) Big Pharma and its army of industry lobbyists in Ottawa is trying to stall the plan until they can kill it outright; and iii) premiers are holding out for federal cash to help pay for “catastrophic” coverage.

Coalition members, including members of the Medical Reform Group are encouraged to participate in the lobby of government. It is important to approach federal, provincial and territorial governments (politicians and departmental officials). Most provinces want progress on the elements of the NPS. Some should be encouraged in their efforts to take leadership on the question of single-payer and better drug management programs (Manitoba, Saskatchewan in particular and others, including B.C. and Ontario on some specifics).

An e-mail message has been sent to all federal MPs, premiers and health ministers to get the issue on their radar and the formal lobbying (meetings and education materials) at

the federal level began with the return of Parliament in April, to complement efforts with provincial and territorial Ministers of Health and departmental officials.

In early February, 2006, the UBC Centre for Health Services and Policy Research hosted a conference and copies of the conference presentations are available at <http://www.chspr.ubc.ca/hpc/?page=presentations>. There were feature presentations by the governments of BC, New Zealand, Australia, and the United Kingdom on how to expand coverage and control drug expenditures on expensive ‘me-too’-drugs as well as a presentation on the Common Drug Review program in Canada.

According to Canadian Health Coalition coordinator Michael McBane, a sign of the conference being on the right track was the national newspaper ads attacking the event. The ads were taken out in the name of CARP (a Toronto-based travel agency for seniors with funding from pharmaceutical and insurance companies). ♦

ONTARIO'S LOCAL HEALTH INTEGRATION NETWORKS—REARRANGING THE DECK CHAIRS?

Karen Trollope-Kumar

The Provincial Liberal Government of Dalton McGuinty is pushing through legislation that will result in major changes in the ways that health care is organized and delivered in the province of Ontario.

According to the Ministry, the Local Health Integration Networks (LHINs) will create a more integrated and regionalized health system. The Ministry of Health and Long-Term care is creating fourteen LHINs across the province, each one responsible for health services in a particular area.

The LHINs legislation represents round two of re-structuring of health services in the province – round one being the process of hospital service restructuring that began in 1996. The scope of this current legislation is even broader, covering a wide variety of health care services as well as non-clinical services within health care facilities.

The LHINs will receive funding from the Ministry, and will have the power to allocate and disburse health care funding within their regions. They will have the power to coordinate services, to create partnerships between health service organizations, and to transfer, merge or amalgamate existing health services. LHINs may change levels of funding for health service organizations and also order providers to start or cease provision of services.

In a recent analysis, the Ontario Health Coalition outlines the various ways in which the LHINs legislation facilitates privatization of health services. Their power to amalgamate health service organizations applies to

non-profits, but not for-profits. In the process of creating partnerships between providers, services may be transferred from non-profit to for-profit services, opening a major new market niche for privatized health services. Non-clinical services can be contracted out through competitive bidding, a move that will undoubtedly result in new opportunities for for-profit corporations to bid on services. Further, there is no protection for the promotion of non-profit and public delivery of health services.

In a recent public education flyer published by the Ministry, the promise is made that the LHINs will be “transparent, accountable, and responsible.” Yet the question of accountability and responsibility of the LHINs is a key concern of critics of the LHINs legislation.

Members of the boards of the LHINs are not elected from the community, but rather are appointed by the Minister. Further, there is no protection against corporate for-profit bias on LHINs boards or among key LHINs personnel.

While the LHINs report to the Minister through accountability agreements, there is little or no provision for public input into the LHINs process. For example, there was no provision for a process of community consultation during the development of the LHINs legislation, nor is there a plan for ongoing community input during implementation and evaluation of the LHINs. Without this process for community input, the issue of public accountability becomes critical.

According to the Ministry's information flyer, the LHINs are meant to “restore equity to Ontario's health system, ensuring quality care for every patient, in every community in the province.” In one strategy to promote greater efficiency of services, access to specialized services such as joint replacements will be centralized at particular hospitals, or “centres of excellence”. While this proposed solution could improve wait times for particular procedures, it is hard to see how it will improve equity. Poor and marginalized patients will undoubtedly have difficulty traveling to regional centres for their care.

Health services for the most marginalized of patients are presently a diverse blend of government agencies and a wide variety of non-profit organizations. Many of these non-profit agencies are heavily supported by volunteers, who work both on the governing boards as well as in the day-to-day work of the agencies.

These non-profits are thus deeply embedded in the communities they serve and are continually nourished by ongoing community input. If such agencies are forced to “partner” with for-profit agencies, that powerful spirit of volunteerism that inspires them may vanish. When a diversity of services is lost through partnerships or amalgamation, it is the poorest who will likely suffer.

Doctors are not subject to the legislation, nor are they part of the governing structure of the LHINs. In a recent statement by the President of the College of Family Physicians on Ontario, Dr Cheryl Levitt ques-

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ONTARIO'S LOCAL HEALTH INTEGRATION NETWORKS (continued)

tions the absence of any input into the LHINs process by family physicians. Family physicians play a key role in the health care system, yet they are neither affected by this legislation nor are they a part of the design or governance of the LHINs.

Opposition to the LHINs legislation has been brisk. The Ontario Health Coalition's analysis of the legislation reveals the emptiness of the government's rhetoric about the legislation and exposes the increase in centralized power that is in fact being created. Unionized health service workers across the province have been mobilized into action to oppose this legislation that clearly threatens their jobs.

The Medical Reform Group has serious concerns about the scope and extent of the power of the LHINs. As a physician group, we can have a significant voice in the debate about this critical emerging issue in Ontario's health care system. ♦

MONEY AND MEDICINE: IN FOR-PROFIT HEALTH CARE, INVESTORS HAVE NO CONTACT WITH PATIENTS, PROFITS LEAVE THE FACILITY AND THE INCIDENCE OF PHYSICIAN FRAUD IS STARTLING

Tony Clement's new position as federal Minister of Health puts him in the centre of an intense controversy over public versus private payment for health care and the role of investor-owned, for-profit health care delivery.

In October 2005, Clement and I participated in a televised political discussion. During the conversation, Clement claimed that contrasting the small-business model of group medical practice with private investor-owned for-profit facilities was "a difference without a distinction".

The subsequent rapid-fire discussion prevented me from fully articulating the enormous importance of the distinction.

There are similarities between the two health-care models. Both small-business group practice and investor-owned for-profit health care facilities are privately owned, and the owners seek to maximize income.

The differences, however, are impressive. First are structural differences. Group practices are generally small; for-profit institutions may be large—major hospitals, for instance. Group practice owners have direct contact with patients; the investors of for-profit facilities do not. Physician-owners of group practices have been trained in a culture of responsibility and caring for patients. Investors have not.

In a group practice, all "profits" stay in the facility. They contribute to the incomes of the workers

and are directly devoted to health care.

In for-profit health businesses, the return to the investors of up to 20 per cent is money that leaves the facilities. It represents resources that could be devoted to patient care, but are not.

These structural differences may influence patient outcomes. Studies of the outcomes of small-business group practices versus other models of outpatient care are unavailable. Comparisons of private for-profit versus private not-for-profit delivery have been conducted and are telling.

A rigorous systematic review of high quality studies comparing for-profit versus not-for-profit hospitals has demonstrated a relative increase of two per cent in death rates in the for-profit facilities. The implications of the study, published after peer review in Canada's top medical journal, are important: If all Canadian hospitals switched from not-for-profit to for-profit status, the result would be 2,200 additional deaths each year.

A similar review, published in a leading American medical journal, showed an eight per cent increase in death rates in largely outpatient for-profit kidney dialysis facilities in comparison to not-for-profit facilities.

The need to satisfy investors leaves less money for patient care. Corners are cut and patients ultimately

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MONEY AND MEDICINE (continued)

suffer. The incentive structure also explains another difference between group practices and investor-owned facilities. Fraud is unusual among Canadian doctors and when it occurs is small scale.

But fraud is common in investor-owned facilities. To cite two examples: one for-profit hospital chain in the United States has paid the largest fraud settlement in American history, \$1.7 billion. Another for-profit chain has paid almost \$400 million in a series of fraud settlements that are still ongoing.

A cynic would suggest that a final set of differences explains the Conservative party's enthusiasm for investor-owned for-profit health care delivery. For-profit health care companies make large political donations, of which the Conservative party is the major beneficiary. The Conservative party has received hundreds of thousands of dollars in donations from for-profit companies providing diagnostic imaging and long-term care services.

Clement is personally familiar with this phenomenon. One long-

term care company donated more than \$43,000 to his unsuccessful campaign for the Ontario Conservative leadership. Two diagnostic test companies, to which Clement's provincial health ministry subsequently awarded contracts, donated \$11,000 to his campaign.

Politicians also reap personal benefits from for-profit health care providers. Retired politicians often sit on boards of directors of companies that deliver, or benefit from, for-profit health care. For instance, Don Mazankowski, lead author of a 2001 report lauding the benefits of for-profit health care delivery, received at least \$204,000 in 2000 for sitting on boards and providing advice for the parent company that owns Great-West Lifeco, one of Canada's largest providers of supplementary health care insurance.

Michael Kirby, chair of the senate committee on social affairs, science and technology, produced an influential health care report in 2002 that recommended expanding investor-owned for-profit health care delivery. Senator Kirby is a director of

Extendicare, a giant for-profit nursing home company, has sat on three of the board's committees and is a major shareholder in the company.

During our appearance on the political talk show, Clement said that he and the Conservative party are committed to publicly financed health care and do not support private pay.

The moderator, Michael Coren, turned to me and said, "You don't believe that, do you?" I must admit, I expressed skepticism. I hope I was wrong, and that as Minister of Health, Clement will aggressively enforce the Canada Health Act, and stop Ralph Klein's—or his successor's—privatization plans.

I also hope that the Conservative government will practice evidence-based health policy. That begins by recognizing the problems with investor-owned for-profit health care, and acting accordingly. ♦

First published April 17, 2006 in the Hamilton Spectator under the byline of Dr. Gordon Guyatt

MEDICAL REFORM GROUP CHALLENGES NEW HEALTH MINISTER

The MRG of Ontario has released an open letter to the new Health Minister, Tony Clement. The letter challenges the new government to deliver on its promises that make sense – and to drop the ones that don't.

“The MRG was delighted with your party's commitment to single-tier health care that you expressed during the campaign”, says MRG spokesperson, Dr. Gordon Guyatt, in the letter.

“Unfortunately, this commitment will be tested in the coming months. Ralph Klein's proposed legislation allowing private insurance for publicly insured services, and allowing physicians to work in both pri-

vate and publicly financed systems, is a gross, blatant, unprecedented violation of the Canada Health Act.”

In the letter, Dr. Guyatt calls on Mr. Clement to speak out forcefully against the legislation, and to “bring the full weight of the Canada Health Act to bear on the provinces should they move forward.”

“We are asking the government to act now,” said another MRG spokesperson, Dr. Ahmed Bayoumi. “Mr. Clement's timely intervention before the legislation is passed could force Mr. Klein to rethink his plan, a plan that violates the fundamental principles of equitable health care.”

In its letter, the MRG raises a second issue, the Tory campaign

promise to introduce guaranteed wait times. The letter argues that guaranteed wait times won't train a single needed doctor, or a single needed nurse. Furthermore, guaranteed wait times substitute length on a wait list for patient's need as a criterion for moving to the front of the line.

“Wait list targets – and especially monitoring of the extent to which targets are met – makes sense,” Dr. Guyatt concludes: “Guarantees do not. A major test for this new government is whether they will make the right decisions to strengthen public health care.” ♦

Released by the Medical Reform Group February 7, 2006

Dear Mr. Clement:

The Medical Reform Group of Ontario (MRG) is a group of physicians and medical students who have been working, for over 25 years, to achieve and maintain high quality health care for all Canadians. We are writing now to present our perspective on possible health care priorities for your new government.

The MRG was delighted with your party's commitment to single-tier health care and the Canada Health Act that you expressed repeatedly and forcefully during the campaign. Unfortunately, this commitment will be tested in the coming months. The previous Liberal government did not fulfill its duty to enforce the Canada Health Act against the extensive violations now going on in Alberta, British Columbia, Quebec, and Nova Scotia. In these provinces, patients can pay to get to the front of the line for imaging procedures such as MRI. Your government could demonstrate its commitment to the Canada Health Act by more aggressively reducing transfer payments as a penalty for these violations.

Ralph Klein's and Jean Chrétien's proposed legislation allowing private insurance for publicly insured services, and allowing physicians to work in both private and publicly financed systems, are gross, blatant, unprecedented violations of the Canada Health Act. We hope that you will soon speak out against this legislation, and bring the full weight of the Canada Health Act to bear on the provinces should they move forward. Your timely intervention before the legislation is passed could force these provinces to rethink their actions, actions which violate the fundamental principles of equitable health care.

We would also ask you to rethink one of your election promises. We understand that the intent of wait time guarantees is to relieve Canadians' anxiety over what they perceive as excessive, sometimes unacceptable, delays in health care. The guarantees, however, have two key limitations.

The first is that they make no attempt to address the underlying problems within the system. For example, Canada has the fewest practicing doctors per capita of any G7 country and we only maintain our above average nursing ratio by raiding third world countries. Guarantees will not train a single additional doctor or nurse.

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MEDICAL REFORM GROUP CHALLENGES NEW HEALTH MINISTER

(Letter continued)

Canada has so far failed to take full advantage of efficiencies that could shorten waiting times. The health sector lags far behind most other parts of the economy in utilizing computerized information technology for ready access to patient information.

We have failed to effectively apply queue-management theory. By and large, for instance, individual doctors keep their own waiting lists. Regional groups keeping a communal waiting list could facilitate quicker access to care. The government should greatly expand short-stay surgical clinics for procedures such as joint and cataract surgery.

Guarantees distract from the real task of implementing these efficiencies, and draw away resources that we need for innovation.

The second major problem with wait times is that they introduce what some have called “perverse incentives” into the system. Currently, doctors in Canada treat patients according to need. The sicker you are, the more you are suffering, the higher priority you have.

Guaranteed wait times introduce another factor into the decision - how long you have been on the list. That would be fine if there was a perfect one-to-one relation between need and length of wait. Unfortunately, that is not the case.

With guaranteed wait times, patients have a strong incentive to get on the list early, even if their problem does not warrant intervention at the time. After all, it might get worse, and once on the list, the clock starts ticking. Time on the list therefore tends to lose any relation to need.

For specialists, lots of quick short first appointments will ensure that patients get off the wait list before the required time runs out. Unfortunately, the process of actually sorting the problem out may lengthen interminably. These two limitations - failure to address the underlying problem, and the perverse incentives they introduce - are the explanation for failed experiments with guaranteed wait times in Europe. Norway, Sweden, and Denmark have all tried and abandoned guarantees. Where they persist, they create an unhealthy tension between treating according to need, and treating according to time on the list.

It is important to distinguish between guarantees, which are likely to prove destructive, and wait time targets associated with rigorous monitoring. Setting guidelines for acceptable wait times, and keeping close track of how we are doing in achieving them, is highly desirable.

In Ontario, an easily accessed website will tell you waits for cataract surgery, joint replacements, CT and MRI scans, cardiac procedures, and cancer surgery in your region. This sort of monitoring is a big step forward. It allows a check on how we are doing in implementing the sensible, needed strategies and investment for reducing waiting times in publicly funded, not-for-profit delivered care.

We believe that your government should make a strong initiative to renew efforts to have provinces establish wait-time targets, to extend them beyond the areas they have so far established, and to rigorously monitor wait times and make them available to the public. We believe that this will be far more effective than guaranteed wait times, and avoid guaranteed wait times destructive consequences.

Thank you for considering the issues we have raised. ♦

MR. HARPER, WE WILL FORGIVE YOU IF YOU DROP YOUR GUARANTEED WAIT TIME PROMISE

The Medical Reform Group prepared the following op-ed days after the election with the following recommendation

Conditioned by past disappointments, Canada's electorate will be watching closely to see if Stephen Harper keeps his election promises. Hampered by a relatively weak minority, Harper may have to pick and choose which promises he keeps.

A general category of promises that are best shelved is election gimmicks—policies that may appeal to voters at election time, but fail the test of fundamental soundness. One such promise that the new Prime Minister would be wise to dismiss is health care wait time guarantees.

Wait time guarantees have the quintessential features of an election gimmick. They address a complex problem, and offer a simple, straightforward, appealing—but misguided—solution.

The intent of wait time guarantees is to relieve Canadians' anxiety over what they perceive as excessive, sometimes unacceptable, delays in health care. The guarantees, however, have two key limitations.

The first is that they make no attempt to address the underlying problem. Canada is experiencing a shortage of doctors, and is increasingly threatened with a serious nursing shortage. Guarantees will not train a single additional doctor or nurse.

Canada has so far failed to take full advantage of efficiencies that could shorten waiting times. The health sector lags far behind most other parts of the economy in utilizing computerized information technology for ready access to patient information.

We have failed to effectively apply queue-management theory. By

and large, for instance, individual doctors keep their own waiting lists. Regional groups keeping a communal waiting list could facilitate quicker access to care. Short-stay surgical clinics for procedures such as joint and cataract surgery should be greatly expanded.

Guarantees distract from the real task of implementing these efficiencies, and draw away resources that we need for innovation.

The second major problem with wait times is that they introduce what some have called “perverse incentives” into the system. Currently, doctors in Canada treat patients according to need. The sicker you are, the more you are suffering, the higher priority you have.

Guaranteed wait times introduce another factor into the decision—how long you have been on the list. That would be fine if there was a perfect one-to-one relation between need and length of wait. Unfortunately, that is not the case.

With guaranteed wait times, rational patients will get on the list early, even if their problem is trivial. After all, it might get worse, and once on the list, the clock starts ticking. Time on the list therefore tends to lose any relation to need.

For specialists, lots of quick short first appointments to ensure patients get off the wait list becomes rational behavior. Unfortunately, the process of actually sorting the problem out may lengthen interminably.

These two problems—failure to address the underlying problem, and the perverse incentives they introduce—is the explanation for failed experiments with guaranteed wait times in

Europe. Norway, Sweden, and Denmark have all tried and abandoned guarantees. Where they persist, they create an unhealthy tension between treating according to need, and treating according to time on the list.

Some observers see a further risk in the guarantees. They worry that Stephen Harper's recent conversion to a believer in the Canada Health Act and equitable health care is insincere. If so, could guarantees be an excuse for establishing investor-owned for-profit facilities that would bail out current delivery systems when patients exceed wait times?

Strong evidence suggests—at least for hospitals and dialysis facilities—that for-profit care leads to poorer outcomes, and higher charges for funders. Governments pay more, the public gets less.

That bad deal for Canadians could get worse if the clinics represent a step toward user pay American-style medicine. Stephen Harper's history suggests we should not dismiss this concern lightly.

It is important to distinguish between guarantees, which are likely to prove destructive, and wait time targets associated with rigorous monitoring. Setting guidelines for acceptable wait times, and keeping close track of how we are doing in achieving them, is highly desirable.

In Ontario, an easily accessed website will tell you waits for cataract surgery, joint replacements, CT and MRI scans, cardiac procedures, and cancer surgery in your region. This sort of monitoring is a big step forward. It allows a check on how well we are doing in implementing the

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MRG PROVIDES INPUT ON FEDERAL BUDGET

The MRG took the opportunity offered by the new Finance Minister, the Hon. James M. Flaherty, to address federal budget priorities in a letter on April 19, 2006

We are pleased to respond to the invitation of the Minister of Finance to address key health priorities for the current and future federal budgets, and trust that they will be received and shared with other stakeholders in the spirit of transparency and accountability with which your government has begun its mandate.

The Medical Reform Group is a voluntary association of physicians and medical students which has been monitoring federal and provincial (predominantly Ontario) funding and delivery issues around the funding and delivery of health services, health protection and health human resources for over 25 years.

MR. HARPER, WE WILL FORGIVE YOU IF... (continued)

sensible, needed strategies and investment for reducing waiting times in publicly funded, not-for-profit delivered care.

Shipping people to the United States, or to investor-owned, for-profit clinics in Canada, won't improve Canadian health care. Switching the criterion for moving to the front of the line from need to length of time on a wait list will be bad for patients.

Mr. Harper, we will forgive you if you drop your guaranteed wait time promise. ♦

Released by the Medical Reform Group January 25, 2006

We have consulted and presented briefs to federal and provincial legislative committees, commissions and inquiries on a range of health-related issues over the years.

Our brief focuses on three main points:

1. The value of our current single-tier publicly funded health care system, not only on grounds of equity, accessibility and quality, but also as a factor in our economic competitiveness.

2. The value of a strategic role of federal partnership in supporting expansion and improvement in service delivery, through strategic supports for not-for profit management and service delivery. Commitment to adequate remuneration for those who provide services, but does not commit Canadians to establishing profit and administration line items for non-provider investors.

3. The value of federal support for pan-Canadian functions such as health protection and health research, the training of highly specialized health care human resources which are typically shared across the country, as well as providing applied research which focuses on the detailed evaluation of innovative delivery approaches.

Nearly 50 years of experience in Canada with not for profit health services administration suggests our single payer approach has many advantages which make us the envy of our neighbours to the south because they are associated with lower employer costs in this country. Numerous commissions and inquiries, as well as senate and commons committees

on health have come up with a remarkably similar trio of recommendations which we urge you to consider adopting as the starting point for any further negotiation with the provinces and territories who are charged with the direct delivery of care. While the order varies from one committee and commission to the next, all have urged aggressive action on:

- Primary care reform
- National pharmacare, and
- National home care.

Some important initiatives have begun to be taken in primary care reform to address the most effective use of health human resources, but much remains to be done, before the wait lists which have occupied so much media attention in the past 4 or 5 years, will subside to a manageable level. As your colleague, the Hon. Tony Clement will tell you, we are already on record as cautioning against the expectation that the proposal for wait time guarantees will do anything more than move the wait lists from one medical condition to another.

A few weeks ago, the second annual report of the Health Council of Canada confirmed yet again the wisdom of several recent committee and commission reports which have made priorities of national pharmacare and national home care. As you will have heard from the Canadian Health Coalition, among others, there is an urgent need to address the increasing anxiety of Canadians at mounting drug prices. We think a strategy which combines the purchasing power of the whole country and

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MRG PROVIDES INPUT ON FEDERAL BUDGET (continued)

involves all levels of government in cost-containment, for example, through insisting on transparency in new trade and patent legislation, can only be good for all of us.

As noted, the other priority for health care service delivery is a realistic approach to home care, which has been the basis of bed closures across the country. Although we have reduced acute care beds by nearly 50 per cent across the country, for the most part there has been little corresponding attention to building community infrastructure which would relieve pressure on the remaining beds.

This is particularly the case for home care services which allow earlier discharges and/or support and maintain fragile Canadians in the community rather than in the hallways of crowded hospitals. It has also not escaped our notice that the informal home care labour force consists primarily of middle-aged women who also risk their own long-term economic security through temporary

absence from the labour force to provide care which is not otherwise available to ill or dying relatives.

While there are obviously a number of ways to address these issues, we would like to recommend that you and your government focus on strategies which focus all available funds directly on service provision, rather than being diluted by adding administrative and profit line items to accommodate for profit operations or tax allowances which tend to favour those with the greatest income, not necessarily those in greatest need.

We think there is a very important role for the federal government in the regulation of safety and effectiveness of health related products and therapies. While we acknowledge the interest of the previous government in cost containment in health protection, we think this must not be done at the cost of patient safety, and so we recommend that, in your review of this important regulatory area, you seek strategies which do not

involve the pharmaceutical and medical device industry in voluntary regulation of a function which has such potential to risk the lives of Canadians.

Similarly, although we think there is an important role for private sector research and development in the health sector, we are not persuaded that this should be linked as closely to federal funding for basic and applied research in health care as has been the case with the previous government.

While we support partnership where it can be demonstrated to be in the interest of all partners, we are concerned that some initiatives of previous administrations have resulted in some research and funding decisions more closely aligned to private rather than public interests.

We look forward to consulting with you on ways to implement these recommendations throughout your mandate. ♦

HEALTH PROVIDERS AGAINST POVERTY

Janet Maher, with files

Since the fact sheet on Special Diets was first published in **MEDICAL REFORM** in the spring of 2005, a small group of family doctors and nurse practitioners in the Greater Toronto Area have become a force to be reckoned with in the growing campaign to advocate to recognize the individual and social costs of avoiding the plight of social assistance recipients in Ontario.

We recently met with member Gary Bloch to review their current agenda. Here is a summary of projects and some of the people

who are working on them [Please also see reports on the campaign from Gary and others elsewhere in this issue]:

1. Ongoing pressure on the privacy complaint which, if successful, could result in a loosening of restrictions on the special diet program, which could allow for millions of dollars to again flow to deserving people living in poverty.
2. A new complaint to the ombudsman (Andre Marin) regarding the persistence of legislated poverty

3. Continued work within the OMA to get them to recognize poverty as a health priority. This will hopefully start with the writing of a policy paper with the Population Health subcommittee to be distributed throughout the organization for eventual approval and publication in the Ontario Medical Review. This is being carried out with Michael Rachlis, and we hope to expand

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HEALTH PROVIDERS AGAINST POVERTY (continued)

- from here to eventually have poverty recognized by the OMA on the level and with the resources they have allocated to smoking and smog.
4. Ongoing lobbying of other health organizations for ongoing support – the Registered Nurses' Association of Ontario, the Association of Local Public Health Authorities, the Canadian Public Health Association, the College of Family Physicians of Canada, and Registered Dietitians.
 5. Requests for meetings with the Ministers of Health, Health Pro-
 6. Ongoing support of grassroots actions by the Ontario COalition Against Poverty, as well as the Hunger March Organizing Committee, and other frontline organizations.
 7. Ongoing alliance with other community groups combating poverty, for example, the ODSP Action Coalition.
 8. Considering legal avenues for challenging low welfare rates and the special diet allowance changes
Gary is eager to hear from colleagues around the province, and the country, to provide resources for other local initiatives, and share experiences and lessons of front-line advocacy. ♦
(In Spring, 2006, Gary Bloch was winner of one of four New Teacher Awards from the Department of Family and Community Medicine at the University of Toronto.)

MCGUINITY GOVERNMENT FORCED TO CORRECT DISABILITY PRIVACY BREACH

In response to a complaint to the Information and Privacy Commission of Ontario, the provincial government has quietly reversed a policy that breached the privacy rights of the tens of thousands of Ontarians who receive social assistance through the Ontario Disability Support Program (ODSP).

In December, 2005, a complaint was launched with the Information and Privacy Commissioner of Ontario by Dr. Gary Bloch, a family physician with St. Michael's Hospital in Toronto.

Prior to the filing of this complaint, the Ministry of Community and Social Services listed ODSP recipients' medical diagnoses in the client files accessible to front-line social services workers.

These diagnoses were reported in the form of codes from the International Classification of Diseases – codes that are accessible on the website of the World Health

Organization. A quick web search by a client's worker could reveal diagnoses including HIV/AIDS and Hepatitis C.

It has been learned that, in January 2006, the government quietly corrected this breach by erasing these codes from every client file.

"The swiftness of the government's response to this complaint indicates both the gravity of the breach of privacy and the public relations nightmare this would have caused if it had become public," states Dr. Bloch. "Unfortunately, it required an outside whistleblower to push the Ministry to bring its records in line with basic standards for the privacy of health information."

This privacy complaint was filed as a follow-up to an outstanding complaint to the Privacy Commissioner, launched in November 2005 by Dr. Bloch, regarding changes to the application form for the "Special Diet Supplement".

The new form requires health providers to check off boxes that openly state their patients' health conditions.

"The government continues to demonstrate that it values the privacy rights of people living in poverty less than those of other citizens," says Dr. Philip Berger, Chief of the Department of Family and Community Medicine of St. Michael's Hospital. "People living in poverty should not be forced to choose between revealing the intimate details of their health status and being able to buy food." ♦
Released by Health Providers Against Poverty, May 2, 2006.

POVERTY -- AN ISSUE FOR THE OMA?

Mimi Divinsky

After some debate about the virtues of trying to change things ‘from within’, Michael Rachlis, Gary Bloch, Melissa Melnitzer, Tara Kiran and I decided to take advantage of our obligatory OMA membership and lobby internally for the OMA to make some official statement about the adverse effects of poverty on health.

Several other professional groups, including Registered Nurses, Dietitians, Public Health Agencies, Community Health Centre physicians, and the Ontario College of Family Physicians had officially supported the recent Raise the Rates campaign, and it was a glaring omission that the official body representing all Ontario doctors hadn’t joined them in pressuring the provincial government to keep its election promise and restore social assistance payments to pre-Harris levels. (In 1996 the Harris government cut welfare payments by 21 per cent, equivalent to 40 per cent in 2006 dollars.) If they needed evidence that living in poverty is the main social determinant of health, we had it in abundance.

Our first meeting was with Ted Boadway (now retired) and John Wellner, Executive Director and Director of Health Policy, respectively. They were welcoming and interested but impressed on us that the OMA, if it had an advocacy role, focused on “the effect on doctors in their offices” and in regards to the Raise the Rates campaign, had heard from doctors frightened or threatened into signing the Special Diet Forms. (See relevant Newsletter articles in this and recent issues of **MEDICAL REFORM**.)

They were very clear that the OMA does not endorse ‘campaigns’. Past experience had taught them cau-

tion; they had “been badly burned” by at least one experience, attributing the disaster to inadequate research on the issue.

If the OMA couldn’t endorse the Raise the Rates campaign, could we educate or have some input into the OMA Forms committee process, given the government’s promise to revise the Special Diet Form yet again?

Answer: The Forms committee dealt with questions, complaints and requests for revision of the approximately 3000 forms ‘shared’ by doctors and the Ministry of Health. Our last minute input into a longstanding historical membership and process was unlikely to be welcome. Nevertheless we have written to them, asking for participation.

Could we bring a motion from the floor, to OMA council?

Answer: Even if brought forward by a Council member, there would be, literally, two minutes to present, two minutes for the Chair to ask questions, and then a vote, almost guaranteed to be “No”. This would most certainly send the issue back into obscurity, exactly the opposite of what we were trying to achieve. If by some chance our statement on poverty was ‘passed’, we needed to know that members’ motions are not binding on the OMA, though “they may be taken seriously by the Board”.

Our best hope was to meet with the OMA Committee on Population Health, (previously chaired by Dr. Chan Shah) who welcomed us, listened carefully, and offered us much sympathetic support. Robert Kyle, the current Chair, reiterated that the OMA process is much slower than

most doctors realize. When Michael praised the OMA’s incredibly successful anti-smoking public policy work, including effecting legislation, we learned that its seeming ‘fast-track’ success was in no small way due to the fact that it was one issue on which all doctors could agree.

By contrast, it had taken over three years to complete a position paper on TB (following an outbreak in a Toronto men’s shelter) and eight years to go from ‘committee’ to a position paper on Homelessness. Our first task, it was clear, was to educate Ontario physicians about poverty in their communities and its effect on health.

We have kept in touch with them by email, but at the last meeting, March 27th, it was understood that they would consider our proposal and let us know if adequate funding existed to hire an unbiased researcher to prepare a thorough document/paper for publication in the Ontario Review. Michael and Gary both offered their research and writing experience towards what we were told was this crucial first step. ♦

QUEEN'S PARK IGNORING LOOMING HEALTH CRISIS

Over the past three months we have been witness to the escalation of a health crisis more dramatic than any we have seen in years.

It will have a bigger fallout than tainted water or SARS, a greater impact than obesity or smoking. The evidence for its existence and impact is strong.

The solution is well within reach, but those who can fix it just allow it to get worse.

This crisis is poverty, and the health risks forced on the hundreds of thousands of Ontarians who live on social assistance.

In November 2005, the Ontario government placed new restrictions on the "special diet supplement." Since then, we have seen a steady stream of our vulnerable patients reporting their welfare cheques have been cut by as much as half.

This supplement has been available for more than a decade, allowing health providers to prescribe extra money for a healthy diet for those who required it. The new restrictions make it almost impossible to obtain for most people who would benefit from it.

The diet supplement became an essential lifeline for welfare recipients after the Mike Harris Conservatives cut social assistance rates by 21 per cent in 1995.

Its importance grew with the failure of rates to rise with inflation and ballooned when the Ontario government refused to allow welfare recipients to keep the federal child benefit.

People receiving welfare today must survive with 40 per cent less spending power than they had 11 years ago.

Make no mistake: The new restrictions to the special diet supplement are simply another welfare cut.

A single mother with two children whom we saw last week had her cheque cut by \$750, leaving her with no money for food once she paid her rent and bills.

Her children, like all those living in poverty, are more likely to develop a variety of illnesses and mental health problems, to experience hospitalization, to perform worse at school and to leave school early.

A young woman with HIV, who came to Canada 10 years ago as a refugee from Rwanda, saw her income fall by nearly a quarter, leaving her with little more than \$750 a month.

Under the new rules, she will only be eligible for special diet funds once she begins wasting away from her disease.

Never before have we been forced to be complicit in an activity that so clearly harms the health of our patients.

Now, the government allows us only to declare whether a patient has one of the few health conditions listed on his form. Further, the amount of money now attached to these conditions is laughable — like the 30 cents a day for a person at risk of heart disease because of high cholesterol.

By requiring us to sign this form, the government is using our positions as health professionals to gain legitimacy for its latest welfare cut.

This cut represents the most recent assault on the incomes of people living on social assistance.

Our patients would love to work, but are inhibited by many factors, from lack of available jobs to physical and mental disability. They do not deserve to be forced into the health consequences of dire poverty, includ-

ing a higher risk of cancer, heart disease, and diabetes.

These conditions are preventable and will cost our health system far more over the long term than this government is saving with these cuts. We feel it is our duty as health professionals to speak out against this attack on our patients' health.

Poverty needs to be elevated to the level of smoking and smog as a target for our health programs.

Last year, in response to the blatant unwillingness of politicians, bureaucrats, and members of our own professions to combat poverty as the leading preventable cause of illness, we formed Health Providers Against Poverty.

We did so because, in one of Canada's richest provinces, thousands of people are going hungry every day. This is not because of famine or drought, or for other reasons beyond our control. People are hungry because they are poor, and the so-called social safety net is full of holes.

The provincial Liberal government raised social assistance rates a paltry 3 per cent in 2004, which is so insignificant as to be insulting.

This month, this government is presenting its spring budget. For the sake of our most vulnerable patients, it needs to include a rollback of the restrictions on the special diet supplement and a 40 per cent increase in welfare rates for all recipients of social assistance.

This will allow low-income people to live in dignity, to feed themselves and their families and it will address a strong, reversible risk factor for poor health for hundreds of thousands of Ontarians. ♦

First published by Gary Bloch and Kathy Hardill as an op-ed in the Toronto Star, March 10, 2006.

SPECIAL DIET ALLOWANCE ACTION KIT: FIGHTING POVERTY TO IMPROVE HEALTH

Health Providers against Poverty have prepared a range of materials to assist in educating colleagues and the broader public on the social determinants of health and the health and social costs of failing to address the basic needs of those below the poverty line.

Recent cuts to the Special Diet Allowance are resulting in a cut to the welfare cheques of thousands of social assistance recipients in Ontario. New regulations, implemented in November 2005, make this allowance almost unattainable, by severely restricting the number of health conditions that qualify, and by cutting the amount of money available for these conditions to insignificant amounts.

This is a health issue! This supplement was intended for health providers to prescribe an income supplement for nutrition to those who, in our professional opinions, require it. The new regulations not only have a negative impact on the health of our clients but impact on our ability to provide the best possible care.

Health Providers Against Poverty, along with other groups, is working to reinstate this benefit and to have social assistance rates increased by 40 per cent. We believe poverty needs to be at the forefront of the health agenda in Ontario, **and we feel we have a duty to speak out.**

The action package has **information** for patients and providers to educate themselves about poverty and health, and the new changes to the special diet allowance; and **tools** to let the government know that this situation is unacceptable, and is a threat to the health of the hundreds of thousands of Ontarians living on social assistance.

If you require more information than is available here or want to link more closely to the campaign, please contact Gary Bloch at gary.bloch@utoronto.ca. ♦

POVERTY LEADS TO A GENERAL INCREASED RISK OF DEVELOPING HEALTH PROBLEMS

It has been well documented that one of the strongest determinants of health is poverty.¹ Literature scans consistently demonstrate the robust relationship between low income and poor health, leaving little doubt that poverty leads to ill health.² Furthermore, Phipps notes that the literature supports the notion that the causal effect is one of poverty leading to poor health, and not the reverse.

Researchers from the University of Toronto have demonstrated convincingly that current welfare rates in Ontario are inadequate to meet the nutritional needs of recipients, for single person, single parent, and two parent family households.³ A survey of food bank users in Toronto dem-

onstrated that 94 per cent experienced some level of food insecurity over the previous year.⁴ Nutritional scientists have argued that social assistance recipients may be at greater risk for income related health inequalities than other low income individuals because generally social assistance is granted only to those with very minimal liquid assets.⁵

Low income results in huge disparities in key health indicators, including life expectancy, infant mortality, disability and long-term illness.⁶ On an individual level, Canadians living in poverty are at higher risk of dying from cancer, heart disease, diabetes, and respiratory diseases.⁷

According to census tract data, Canadians living within the

poorest 20 percent of urban neighbourhoods have much higher mortality rates for cardiovascular disease, cancer, diabetes and respiratory diseases than other income groups.^{8,9} Twenty three percent of all premature years of life lost to Canadians are attributable to income differences.¹⁰

Analysis of the 1996-1997 National Population Health Survey (NPHS) indicates that food insufficient households had significantly higher risks of having poor functional health, of suffering from multiple chronic health problems, of having major depression and psychological distress as well as being significantly more likely to report having heart disease, diabetes, high blood

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POVERTY LEADS TO A GENERAL INCREASED RISK OF DEVELOPING HEALTH PROBLEMS (continued)

pressure and food allergies.¹¹ Analysis of the NPHS for the 1998-99 data show that approximately one in five people living in food insecure households reported having at least three chronic conditions.¹²

These effects accumulate across the lifespan. Children's immediate and future health is especially susceptible to such exposures to material deprivation.¹³ Canadian children living in poverty are more likely to develop a variety of illnesses and injuries, and are more likely to experience hospitalization, mental health problems, lower school achievement, and early school leaving.¹⁴

Why the Raise the Rates Campaign?

Welfare rates in Ontario were cut by 21.6 per cent in 1995, and have decreased, in real terms, steadily with inflation in the ten years since, leaving recipients with 21 to 37 per cent less spending power than they were entitled to in 1994. Welfare incomes in 2003 in Ontario provided 35 to 59 per cent of the income needed to reach the poverty line (depending on the size of the family receiving assistance).¹⁵

Research on low income families and food insecurity has concluded that household food insecurity appears inextricably linked to financial insecurity.¹⁶ People living on social assistance have been shown to be at much greater risk of food insecurity than those with other income sources.¹⁷ Food shortages may be caused by circumstances such as having to pay bills for essential services (such as rent, electricity or telephone) or by unusual expenditures such as changing place of residence, purchasing a child's birthday gift or needing to buy a school uniform.¹⁸

However, it is common among low income families that they simply do not have enough money to be able to purchase food to last the entire month. This then precipitates the use of strategies to augment resources such as borrowing money, utilizing foodbanks, reducing portion sizes and "stretching" meals with low cost ingredients. In addition, people use other strategies such as failing to make full rental payments, sending children to a friend or relative's home for a meal, delaying payment of bills, giving up services such as telephones and selling or pawning possessions.¹⁹ In the context of poverty, feeding a family is a constant struggle, placing anxiety about food and the lack of it to the forefront of daily living.²⁰

The campaign to approve the Special Diet Supplement for all social assistance recipients in Ontario rests on the belief that, given the inadequacy of current welfare rates to cover basic needs for shelter, clothing, and food, living on currently available levels of social assistance places one at high risk for nutritional deficiency and other health conditions strongly associated with poverty. The Special Diet Supplement helps to mediate these risks. With the decline in welfare rates, the exceptional need for a "special diet" has become a general need to prevent nutritional deficiency.

Ultimately, this campaign's goal is to advocate for an overall 40 per cent increase in welfare rates for all recipients of social assistance, to fundamentally address a strong, reversible risk factor for poor health for hundreds of thousands of Ontarians. For further information about the campaign to Raise the Rates, please see ocap.ca/taxonomy/term/44. ♦

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A PATH WISELY AVOIDED: FOR-PROFIT BOUTIQUE CLINICS AND THE ROAD TO THE DESTRUCTION OF MEDICARE

Natalie Mehra, Ontario Health Coalition

This is a summary of an analysis undertaken by the Ontario Health Coalition on behalf of the Council of Canadians, the Ontario Association of Community Health Centres, the Medical Reform Group, and the Registered Nurses' Association of Ontario. For the full report, please see the OHC website at www.ontariohealthcoalition.ca.

An emboldened private for-profit health industry is making inroads in primary health care in Canada's largest provinces. In Ontario's urban centres the number of these investor-owned for-profit physician clinics is growing. These clinics are distinguished from normal fee-for-service family practices by their corporate ownership, their co-mingling of OHIP-covered and uninsured services, their high fees selling pay-your-way to the front of the line health care, and the limited size of their practices.

This report looks at the impact of the for-profit corporate health clinics in Ontario on cost, human resources, and number of patients served. The report looks at the future growth of the industry and its consequences on patient access and health system costs.

The research shows that the growth of this industry will exert an inflationary pressure on physician costs in the public system. This model of for-profit medicine is obviously unsustainable and produces social, economic and medical harm to the vast majority of Ontarians for dubious, if any, benefit for a small number of those with income to spare.

- For every 8 - 10 physicians that move into the for-profit boutique medicine industry there is a cost increase of approximately \$1 million.

- For each family physician that moves into a for-profit boutique clinic 800 - 1,350 patients lose their GP.

- Physicians in Copeman for-profit clinics cost 212 per cent of the average salary of a Community Health Centre physician and 150 per cent of the average payment for a fee-for-service physician.

- Physicians in Copeman for-profit clinics cost 519 per cent of the average cost per patient for the highest-paid Community Health Centre physicians and 330 per cent of the average cost per patient for fee-for-service physicians.

- If 10 per cent of Ontario's family doctors limited their practices and increased their fees in the way that the Copeman for-profit clinic physicians have done, 626,000 Ontarians would lose access to a family doctor and the cost would increase by approximately \$100,000,000 per year.

- If 20 per cent of Ontario's family doctors limited their practices and increased their fees in the way that the Copeman for-profit clinic physicians have done, 1,252,000 fewer patients would have a family doctor and the cost would increase by approximately \$200,000,000 per year.

- If 50 per cent of Ontario's family doctors limited their practices and increased their fees in the way that the Copeman for-profit clinic physicians have done, 3,132,000

fewer patients would have a family doctor and the cost would increase by approximately \$500,000,000 per year.

These findings echo those in Ontario's experiments with for-profit MRI/CT clinics and the for-profit cancer treatment centre at Sunnybrook Hospital. They reinforce world-wide evidence about for-profit healthcare.

The majority of Ontario's for-profit MRI/CT clinics were found to have poached scarce technologists and physicians out of the public hospital system. 5 of the 8 clinics have been converted from for-profits into non-profits. The Sunnybrook cancer centre was found to cost \$400 more per patient by the provincial auditor and was brought back into the public system. ♦

VALUING HEALTH PROTECTION

The Medical Reform Group wrote the Privy Council Office in Ottawa on January 12, 2006 to support the Canadian Environmental Law Association brief on health protection.

I am writing on behalf of the Medical Reform Group to advise you of our support for the NGO position paper on the proposed Government Directive on Regulating, "Protection and Precaution: Canadian Priorities for Federal Regulatory Policy," prepared by Hugh Benevides of the Canadian Environmental Law Association.

The Medical Reform Group, a voluntary association of physicians and medical students has been active for over 25 years monitoring Canadian health and social policy with the objective of maintaining and enhancing access to high quality health care in our country. We have observed the current consultation with some concern, given the recent tendency of government policy proposals to fo-

cus on a version of risk management which treats health protection as only a consideration rather than a guiding principle for action.

We believe the Canadian Environmental Law Association brief represents those concerns and makes a number of constructive recommendations to address them.

I look forward to being involved in the ongoing consultation. ♦

CANADIAN ASSOCIATION OF PHYSICIANS FOR THE ENVIRONMENT

The Canadian Association of Physicians for the Environment (CAPE) is an organization of doctors and other health care professionals concerned with the health of our environment and its impact on humans. Its work ranges from education to active lobbying and its issues from climate change and air pollution to pesticide by-laws and the regulation of chemicals.

Problems that are both environmental and health care-related are a natural fit for CAPE, problems like the use of the phthalate DEHP in medical care, the subject of one of CAPE's latest campaigns.

Diethylhexyl phthalate (DEHP) is part of a family of chemicals used to soften plastics, particularly the environmentally-unfriendly polyvinyl chloride (PVC). A solvent in cosmetics and a softener for plastic consumer products, DEHP is used widely in health care to keep tubing flexible, and in blood and intravenous bags. DEHP can make up as much as 20 to 40 per cent of the product.

But DEHP leaches out of the plastic as you use it, into the body of whoever is connected to the tube.

Several government agencies have concluded that at-risk patients, mostly infant boys, are exposed to potentially unsafe amounts of DEHP while receiving medical care.

A June 2005 study by Harvard researchers of 54 newborns in intensive care found that infants receiving the most invasive procedures had five times as much of DEHP's breakdown products in their urine as babies with few procedures.

Health Canada, in its draft position on DEHP in medical devices has acknowledged that DEHP has the potential to cause, in humans, the kind of adverse reproductive and developmental effects seen in rodents. Of greatest concern is the risk to developing testes. Health Canada's draft position calls for the use of alternatives to DEHP-containing PVC tubing for vulnerable groups like infant males where they may be exposed to high doses. But no action is being taken.

Exposure to DEHP is environmental as well. The Canadian government officially declared DEHP an environmentally toxic substance over a decade ago. Due to its wide use,

DEHP and many other phthalates are everywhere; we consume them everyday. And as the various phthalates work in similar ways it is important to look at their combined exposure.

New studies continue to link phthalate exposure to effects on boys' reproductive systems. A European study last year found decreased free testosterone levels in 3-month-old boys associated with higher levels of breast milk phthalates. A U.S. study in the same year showed that infant boys whose mothers had higher prenatal phthalate levels were less masculinized on average.

Working to reduce exposure to DEHP through health care is an important first step CAPE can take in decreasing overall DEHP exposure. It will help protect infants most at risk, reduce the total burden of phthalate exposure in Canada, and decrease our use of PVC plastic, the most environmentally hazardous of all plastics.

Safer and affordable alternatives exist. Your help will be needed to spread the message that DEHP is a potential problem in our hospitals, and that children need to be protected. ♦

Kapil Khatter—CAPE

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

Ida Hellander

In this update Dr. Ida Hellander at Physicians for a National Health Program summarizes their recent activities and campaign priorities.

PNHP has trained about 300 physicians as speakers and spokespeople around the country in the last two years. Drs. Rosana Pellizzari and Joel Lexchin have helped us with information on Canada's health system.

We've been trying to keep up with and respond to attacks on the

Canadian system that followed the Chaoulli decision. Much of the coverage here is touted here as "further proof" that the Canadian system is falling apart.

We've done a lot of media on single payer recently. Among these, Paul Krugman had a series on health care reform in the New York Times that championed single payer.

We are participating in a lot of debates with supporters of Health Savings Accounts, like the American

Medical Association and the right wing think tanks and speaking to more groups than ever, including surgeons. Surgeons!

Many candidates in the mid-term elections are coming out for single payer (although PNHP can't endorse candidates, we are happy to see it).

There is a new grassroots group for single payer in the US, Healthcare Now (www.healthcare-now.org) based in New York. ♦

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

MRG SPRING MEETING--REFLECTIONS ON 1986

June 2006 marks 20 years since the debate on the so-called Ontario Health Care Accessibility Act of 1986, the passage of which marked the end of the Doctors' Strike in Ontario. We're holding a social evening to mark this historic event.

**Join Us at the Free Times Cafe
320 College Street, Toronto (just west of Spadina)
Saturday, June 24th, 2006
8 to 10 pm**

Speakers include several MRG participants in the events of June-July, 1986, including

- ◆ Philip Berger, Chief of Family Practice at St. Michael's Hospital;
- ◆ Rosana Pellizzari, Medical Officer of Health for Perth County;
- ◆ Michael Rachlis, health policy analyst and author; as well as
- ◆ Ann Silversides, free-lance writer, former Globe and Mail reporter covering the strike

Light refreshments

MDs and others: \$30

Students: \$10

Tickets from the Medical Reform Group (space limited)

Medicalreform@sympatico.ca or (416) 787-5246

**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 [e-mail]