

Medical Reform

Newsletter of the Medical Reform Group

Issue 142

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SELF-INTEREST OVER PUBLIC INTEREST

Gordon Guyatt

Any proposed change to health care implies winners and losers. Take a national pharmacare program: Winners would include poor Canadians who have difficulty affording drugs, middle-income Canadians with high drug costs and anyone facing catastrophic drug expenses.

Large industry would also benefit by enhanced competitiveness as a result of lower employee health benefits.

The losers? Canadians in high tax brackets and the insurance industry. The Canadian Medical Association has suggested that provincial governments increase reliance on private, for-profit providers to deliver publicly funded health care.

They suggest physicians be allowed to practise in both for-profit and not-for-profit sectors. In such event, who would win and lose? The CMA says the public would benefit from shorter waiting lists. But long wait times and suboptimal care are, in large part, a function of doctor and nursing shortages. For-profit clinics would not lead to the training of a single additional doctor or nurse. Indeed, such clinics would suck desperately needed personnel from not-for-profit hospitals and clinics.

Physicians practising in public and private settings have a vested interest in keeping waiting lists long in publicly funded facilities. Otherwise, why would patients pay extra to go private?

Could for-profit clinics shorten waiting lists by creating more resources, such as operating-room time? Yes, but government could create the same resources by investment in hospitals or not-for-profit surgical and diagnostic facilities.

Investing in non-profit facilities has a major advantage. For-profit providers need to earn a return - typi-

cally 15 to 20 per cent - for their investors. Non-profits can devote that money to patient care.

So, too bad, no public win in waiting-time reduction.

Others, however, would be winners. Physician entrepreneurs, such as incoming CMA president Brian Day, who operates a private hospital facility, stand to make a lot of money. Many have made huge sums in U.S. for-profit health care. The proposal would allow them to exploit the public expenditures on Canadian health care. And, if another CMA proposal to expand private insurance comes to pass, the insurance industry will cash in.

The losers? The general public, who will end up spending more on health care to feed the investors' profits and on administrative costs associated with private health insurance. Also, those patients who can't afford the direct charges that - as experience in B.C. and Quebec has shown - comes with for-profit health-care provision. These losers will suffer the consequences of two-tier health care: long waits in non-profit facilities to allow for extra charges for queue-jumpers.

Other losers? Health workers who believe that ethical medical

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Provincial Election Forum-- Wednesday, September 25, 2007	

Please visit our website at: <http://www.medicalreformgroup.ca>

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Opinions expressed in **MEDICAL REFORM** are those of the writers and not necessarily of the Medical Reform Group.

Editorial committee this issue: Norman Kalant, Rosana Pellizzari, 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.

EDITORIAL NOTES

Janet Maher

The fall issue is usually our largest of the year, and this is no exception.

The CMA has disappointed us with its drift to seeing the expansion of private health care as the solution to a litany of problems, despite the evidence and despite the clearly expressed commitment of the great majority of Canadians to a universal, publicly funded system.

In this issue, we reproduce commentaries and analysis of our members from a range of sources. The lead article is an op-ed on the CMA meeting discussions from Gordon Guyatt. It complements Irfan Dhalla's commentary of July 3rd, 2007 in the CMAJ. Norman Kalant adds a timely analysis of the Quebec Castonguay Commission, cautioning us all that the Quebec 'father of Medicare' has changed his spots in a way that should give us all pause.

Another approach is represented by Michael Rachlis and Joel Lexchin, who prepared summaries of the presentations they made at the SOS Medicare Conference in Regina in May of this year. As usual, they review the evidence, identify problem areas, and make constructive proposals to address, in the case of Rachlis, ways to improve primary care; in the case of Lexchin, a strategy for moving toward national pharmacare as an antidote.

The other issue on the calendar of Ontario members is our first fixed date election and a referendum on proportional representation, set for Wednesday, October 10th. We go into this election with the provincial treasurer crowing about a recently discovered 2006-07 budget surplus of \$2.3 billion (paralleling a recent announce-

ment by federal finance minister Flaherty of a \$3 billion surplus at the federal level)--the product of nearly a generation of governing parties trying to outdo each other in creating room for tax cuts. All the while, neither federal nor provincial level of government is prepared to step up to the plate as we daily hear about

- ◆ Decaying municipal infrastructure across the country;
- ◆ Declining and decaying housing and community service stock;
- ◆ Social assistance and supports to the most vulnerable that remain at the same level as 20 years ago.

At the same time, our federal and provincial governments seem to spend an inordinate amount of their time devising ways to avoid not only the 5 principles of Medicare but also to the national and international commitments to human rights, the environment and humanitarian assistance that historically distinguished Canada from much of the rest of the world.

As part of its constructive approach to poverty reduction, the Steering Committee has recently endorsed the call of a coalition of voluntary organizations led by Campaign 2000 for a legislated provincial strategy with timetables, targets, resources and an audit process. They will also be looking at their September Steering Committee meeting at strategies and interventions to give substance to the call to reduce poverty by 25 per cent over the next five years.

As always, we encourage your response and feedback to the items in the newsletter. ◆

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SELF-INTEREST OVER PUBLIC INTEREST (continued)

practice requires treating patients according to need, rather than ability to pay. Indeed, while many doctors disagree strongly with proposals that would undermine public health care, the CMA leadership has chosen self-interest over public interest.

How will politicians respond to the CMA initiative? On one hand, Stephen Harper has done nothing to rein in expansions of charge-the-patient for-profit care in Quebec and B.C. On the other hand, the Prime Minister acknowledges the current reality.

In a letter responding to Ralph Klein's proposal to allow physicians to practise in public and private systems, Mr. Harper wrote: "Dual practice creates conflict of interest for physicians as there would be a financial incentive for them to stream patients into the private portion of their practice. Furthermore, dual practice legitimizes queue-jumping as it provides an approved mechanism for patients to pay to seek treatment at the front of the line."

If the federal government decides to have nothing to do with the CMA's proposal, the losers will be the doctors and investors eager to turn health care to profit, and the winners will be the Canadian public. ♦

First published as an op-ed in the Globe and Mail, August 1, 2007

CANADIAN MEDICAL ASSOCIATION CHOOSES NARROW SELF-INTEREST OVER PUBLIC INTEREST

Yesterday, the CMA released a document calling for increased private health insurance and allowing doctors to work in both for-profit and not-for-profit settings.

"The CMA is following a shameful recent tradition of putting doctors' narrow self-interest above the public interest," said Medical Reform Group spokesperson Ahmed Bayoumi.

The CMA's rationale is that the move will reduce waiting lists. Waiting lists, however, are largely a function of inadequate numbers of health workers. "A parallel private-pay, for-profit track in the health care system won't train one new doctor, or one new nurse," another MRG spokesperson, Dr. Shelley Sender, pointed out.

Rather, allowing physicians to practice in both settings creates a situation in which it is in physicians' interest to maintain waiting lists in publicly funded settings. "Why would patients pay extra if waiting lists are under control in publicly funded hospitals and out-patient clinics?" Dr. Sender queried. "Of course, they would not. For-profit clinics can prosper only so long as

not-for-profit provision suffers for unacceptable waits."

In addition to maintaining or exacerbating wait times, the CMA's suggestion would advance two-tier care, which has already gained a foothold in Quebec and British Columbia.

The CMA proposals fly in the face of problems that even the Prime Minister acknowledges. Replying to Ralph Klein's suggestion to allow physicians to practice in private and public pay settings, Stephen Harper, in an April 3, 2006 letter, wrote:

"Dual practice creates conflict of interest for physicians as there would be a financial incentive for them to stream patients into the private portion of their practice. Furthermore, dual practice legitimizes queue-jumping as it provides an approved mechanism for patients to pay to seek treatment at the front of the line."

"Many Canadian physicians – including the MRG – have a different view than the CMA," Dr. Bayoumi concluded. "Physicians should be helping to build public health care – not destroy it." ♦

Released by the Medical Reform Group July 31, 2007

LESSONS FROM THE SPECIAL DIET CAMPAIGN

Gary Bloch

Health Providers Against Poverty (HPAP) now has over two years' experience with the special diet campaign and its associated antipoverty clinics. This project started as a low-key experiment involving a handful of health providers, in partnership with a powerful antipoverty group, the Ontario Coalition Against Poverty (OCAP). It has evolved into the creation of HPAP, an autonomous, multifaceted organization. There are a number of important lessons to be learned from these first two years, which can help guide us forward, and hopefully guide other groups of front line health providers setting out to tackle social determinants of health.

A Brief History

The special diet campaign started in early 2005, when OCAP noticed a regulation in Ontario social assistance legislation that allows for health providers to approve up to \$250 as an extra income supplement for dietary measures to combat health issues. For someone living on welfare (in Ontario a single person receives about \$540 a month, including money for rent), even half that amount is a huge addition to their income.

OCAP workers set out to find health providers willing to assess and prescribe this supplement to people living in poverty. An initial small group of street nurses evolved into a much larger, multidisciplinary group of providers over the ensuing six months. These providers began to conduct focused clinics in which they assessed hundreds of people for this supplement.

The culmination of this first round of clinics was a massive out-

door event in October 2005, on the lawns of the Ontario legislature at Queen's Park, at which 1,000 people living on social assistance were prescribed the supplement, assessed by 40 health providers.

These clinics were never intended to stand alone, however. From the first clinic, we made clear that our involvement would not be limited to prescribing the special diet supplement. We were interested in using these events to highlight the link between health and poverty, and in lending our health expertise to those working to end poverty in Ontario. We have focused specifically on increasing social assistance rates, by at least the forty percent they have dropped in real spending power over the last 12 years.

Along with the clinics, we have engaged in diverse advocacy efforts, including meetings, letters, rallies, and submissions to government committees and hearings. We have taken our message to all three levels of government, and even delivered a cake to the Minister of Social Services. We have also worked to raise awareness among health providers and have met with and gained support from major organizational bodies for nurses, physicians, and dieticians.

It has been a wild ride, and it's high time for a little reflection. I present here four lessons learned through my involvement in this campaign.

Some Lessons Learned

1. Engaging with non-traditional health determinants often requires partnership with non-traditional allies.

The special diet campaign, and the formation of HPAP, would

not have emerged without our alliance with OCAP. Traditionally seen as a radical antipoverty group, and known for its involvement in tense confrontations at Queen's Park, most of us were initially a little hesitant to ally with this group. Non-involved health providers have consistently pointed to this alliance as a source of significant discomfort in their considerations about whether to join our group.

In OCAP, however, we found a true grassroots antipoverty group, with a network of supporters (mostly people living in poverty) that numbers in the thousands. Unencumbered by a traditional organizational structure (usually involving a board, by-laws, and endless inward-looking meetings), OCAP is able to listen to the needs of people living in poverty and creatively respond quickly and with ease.

It is hard to imagine another organization that would have been able to so quickly mobilize thousands of people living on social assistance to come to these clinics, and to stay involved in a loud campaign to give voice to the needs of Ontario's poorest. I do not believe this campaign would have had the impact it has had without the central organizing capacity of OCAP.

2. While addressing non-traditional health determinants often requires out-of-the-box thinking, always grounding the interventions in evidence.

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LESSONS FROM THE SPECIAL DIET CAMPAIGN (continued)

The goal of the special diet clinics is to treat poverty as a health risk, similar to other health risks such as smoking or hypertension. We faced a challenge in justifying this intervention, in that there are no guidelines on treating poverty as front line health providers. We began by collecting the evidence on health and poverty in Canada, which is plentiful, and used this to frame an evidence-based justification for our actions. We even discovered an International Classification of Disease code for poverty, and one for inadequate social assistance rates, which made us more confident that other health experts support the framing of poverty as a health issue.

Our public statements emphasize the evidence on health and poverty, and our submissions and articles frame the issues using an evidence base as well. We are very aware that if we wish to grow our base of support among health providers, we need to speak our common language, which is grounded in strong evidence.

3. Stay true to ethical and legal boundaries.

Many outsiders have framed this campaign as a deviation from ethical health practice. There is a perception that, in prescribing this supplement to so many people, we are flouting the law, and tarnishing the reputation of our fellow professionals. A quick explanation or visit to one of our clinics often dispels these fears, however.

We have always adhered to the letter of the law and of good practice in how we structure our clinics. A chart is created for every client, with a recording of basic demographics, and these charts are kept in a secure location.

The encounter is structured in the traditional SOAP format. As regulations have changed, we have changed the way in which we conduct our assessments, and the questions we ask clients, to conform with current rules.

When the clinics started, the structure of the special diet program allowed us significant leeway in diagnosing the health issues that qualified clients for the supplement. We were able to diagnose clients with “poverty,” which we argue is a health risk akin to others we diagnose on a daily basis. This diagnosis formed the basis for a prescription of the full \$250/month to every person living on social assistance.

The government since changed the process, and defined the qualifying diagnoses much more tightly. Since the change, we have conducted focused assessments of clients to determine their eligibility for the diagnoses listed in the regulations as qualifying for the supplement. This has resulted in most clients not receiving the full \$250 supplement, but we believe that even \$30 per month extra may have a significant health benefit.

4. Don't lose sight of your core purpose.

Once the campaign picked up speed, there was a strong temp-

tation to leave the special diet clinics behind, and to focus on policy discussions and lobbying meetings with “people in power”. We have consistently reminded ourselves, however, that we started out to directly alleviate the poverty of people living on social assistance, and we draw our legitimacy and strength from continuing to undertake that intervention. While our activities have broadened significantly to include strong outreach to health providers, government officials, and the general public, we have continued to directly address the health risks posed by people's poverty through the special diet clinics, and to maintain our alliance with OCAP and other grassroots antipoverty groups. Many of our most interesting and impactful subsequent activities have evolved from these relationships.

Conclusion

These four lessons represent an initial attempt to garner some generalizable ideas from our experience with the special diet campaign. This campaign, and the associated work of HPAP continues, and will continue to result in important learning and reflection for its participants. Through this process, we hope to develop a knowledge base to aid in the development of similar projects by front line health providers aimed at affecting the impact of social determinants of health directly. ♦

STRENGTHENING THE MANDATE OF ONTARIO PUBLIC HEALTH UNITS

Rosana Pellizzari

Ontario Public Health units are involved in an update of their mandate that should result in a stronger role in addressing the social determinants of health.

As part of “Operation Health Protection”, announced in June 2004, the mandatory programs and services delivered by the 36 local public health departments across the province are being overhauled. Long overdue, this revision will see a stronger emphasis on environmental health and the addition of emergency preparedness for public health. Objectives in 14 program areas have been identified, and corresponding requirements will form the basis for evaluation and review.

Although many public health sector professionals had advocated for a distinct “Social Determinants of Health” program that could have mandated targets, e.g. in the reduction of poverty which would have highlighted the role of healthy public policy, the new public health programs will have, instead, a foundational standard that recognizes the importance of social inequities as root causes of health disparities.

The new standards begin with a statement of principles that includes “Effective public health programs and services take into account the

impact of determinants of health and needs on the achievement of intended outcomes. They also require the identification of appropriate roles within the capacity of boards of health to implement those interventions, in collaboration with partners...

The determinants of health will often inform what interventions are needed most...”

The foundational standard, meant to inform all public health standards, goes on to require boards of health to use the social determinants of health to assess the population’s health, and to make public policy-makers, providers and the public aware of both the factors that determine the public’s health and the effective methods to address them.

The next step requires that accompanying protocols be written. This is expected to take place over the fall and early winter, with implementation scheduled for the spring, early in the mandate of the next provincial government.

Between now and then, there is the small detail of an election. Boards of Health, and public health staff, including Medical Officers of Health, are planning to engage in advocacy that would lead to all parties committing themselves to undertake

a comprehensive poverty reduction plan if elected.

In Toronto, the Medical Officer of Health, Dr David McKeown, is on the record calling upon the Premier to effectively address poverty in Ontario. He will lend his support to local efforts of coalitions to unite in a call aimed at all parties to set measurable and publicly accountable targets for the reduction of poverty rates. The party that forms the next provincial government will be expected to report back on the attainment of these targets.

Provincial governments in Quebec and Newfoundland have already embarked on meaningful poverty reduction initiatives. Countries such as the UK, Ireland and Sweden have already made progress in reducing health inequities based on social disparities. There is no reason why Ontario cannot do the same, and more reason for the province’s public health units to see themselves as advocates and partners.

The promotion of health and well-being must address important determinants of health if it is to be effective. Boards of Health and their staff are finally poised to advocate more strongly and consistently on behalf of their communities in this regard. ♦

SAFER VISIT (continued from page 19)

The challenges we face in developing health systems in the DRC are to find strategies that are both sustainable and empowering. I witnessed an unimaginable resiliency among Congolese people, a potential that was so

powerful that it is impossible to ignore. Irrefutably, the women of the DRC have been ignored by the rest of the world. I think it is time that we witness a change. ♦

Brad MacIntosh is a former Steering Committee member and Vice-Chair of SAFER. In early 2007, he traveled to DRC to investigate local conditions. Brad is currently pursuing a Postdoctoral Fellowship in Clinical Neurology at Oxford.

PUSHING THE BOUNDARIES OF DIRECT TO CONSUMER ADVERTISING

Member Debby Copes sent the following letter on August 10th to the Advertising Standards Council of Canada, the president of the Canadian Medical Association, and the Minister of Health seeking their response on this recent attempt by a drug manufacturer to focus direct to consumer advertising at young people. At press time, we had not received an answer from either the council, which offers a reply within 10 working days, or the minister.

Advertising Standards Canada
175 Bloor Street East
South Tower, Suite 1801
Toronto, Ontario M4W 3R8

Re: Janssen Ortho Tri-cyclen lo advertising campaign

We are writing to lodge a complaint with the Council regarding a recent advertising campaign which has been brought to our attention. In particular we would draw your attention to the website www.trythistrythat.ca which appears over the banner of Janssen Ortho, and includes promotion for their product tri-cyclen lo which we believe violates the current industry standard regarding what is commonly referred to as Direct to Consumer Advertising of a prescription contraceptive.

We are concerned that in addition to violating the spirit of the voluntary standard, and in spite of an apparent legal waiver asserting the site owner's intent to make information available only to those over 18 years of age, the page featuring the 'important legal stuff' is blocked from access by most browsers, and need not be viewed as a condition of entering the site. Moreover, we believe the suggestive message of the video track violates the association between the activities or indications for the drug, by manipulating the multiple forms of the word try/tri:

Try laughing, try crying, try taking the lead

Try being bad, try being good

Try staying in bed until noon, try being your own girl

Ask your doctor if tri-cyclen lo is right for you (transcript of the sound track).

While we would encourage public educational material which promotes healthy sexuality for young people and adults, we think it is particularly unethical to focus advertising which exploits community ambivalence about safe sex to young people.

We look forward to your early and review of this complaint, as we understand there are additional formats and additional public venues planned for this product in the coming weeks. ♦

CLAUDE CASTONGUAY: ON THE ROAD TO DAMASCUS OR THE ROAD TO THE BANK?

Norman Kalant

Ontario and Quebec both have public healthcare systems to provide medical care and hospitalization to those who are ill and can benefit from such care.

In the main they experienced the same historical development, but differences in their political

and cultural past had distinct influences on several major aspects of the healthcare systems chosen.

Prior to the onset of World War II Alberta and Saskatchewan had initiated medical and hospital care plans in urban areas. The depression of the 1930's led to an increasing

demand for widely applicable pre-paid insurance, particularly to cover unexpected hospitalization, but resistance from medical associations and business associations blocked such a development. Information collected from routine physical examination of recruits to the armed forces revealed

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CLAUDE CASTONGUAY (continued)

an unexpectedly high incidence of malnutrition and morbidity resulting from the poverty and the associated lack of medical care during the depression.

An advisory committee with representation from the federal government and from professional associations held public meetings to consider proposals for federal subsidies to the provinces to enable the provinces to establish comprehensive medical care programs. Support was virtually unanimous and enthusiastic – labour, farmers, medical associations, insurance companies and the population at large.

However the provincial governments considered the cost in lost revenue (as a quid pro quo for the subsidy) to be too great and no progress was made. Within the next few years Saskatchewan, followed by BC and Alberta, introduced their own government-run hospital insurance programs. In the next federal election campaign the prime minister grudgingly agreed to provide a subsidy to support such programs if enough provinces agreed to join a national scheme. At a federal-provincial conference in 1955 such an agreement was reached and within a few years each province had its program in place.

Subsequently Saskatchewan again led the way by introducing its own medical care insurance. The federal government then set up a Royal Commission to make recommendations on the question of a federally subsidized medical care program; the Commission report, submitted in 1964, strongly endorsed the concept of a provincially administered plan, subsidized by the federal government up to 50 per cent of the cost. With the strong support of the Minister of

Finance, the legislation was passed; when it came into effect in 1968 only Saskatchewan and BC were ready, other provinces qualifying by 1971.

Ontario and Quebec

Ontario residents had previously had a comparatively high enrollment rate in commercial hospitalization insurance plans, and once Parliament passed the Hospital Insurance Act (1957) replacement of the private, for-profit plans by the government –sponsored insurance plan (OHIP) was accomplished without difficulty. With passage of the Canada Health Act, Ontario maintained the insurance concept with an annual premium and enlarged the scope of services to correspond to the spirit of the Health Act.

For Quebec, the period 1961-1966 was one of many major political, cultural and economic changes, collectively producing “the Quiet Revolution”. There was a break from the ultraconservative, church-dominated era of Premier Duplessis as the new government of Jean Lesage introduced programs in rapid succession to modernize many aspects of life, and the introduction of hospital and medical care were among much more sweeping changes. Despite the activity on many fronts, there was much careful planning.

One of the initial tasks was to decide on the administrative structure of an old age/retirement pension plan for Quebec (other provinces had accepted the plan proposed by the federal government). Quebec chose an arrangement by which each generation provides its own pensions; so far this has worked well. Based on the recommendation of the Hall Commission, Quebec set up a committee to propose the structure of a

publicly-funded Health Insurance Agency. In its final form it was based on the same five principles as embodied in the Canada Health Act.

However Quebec went further, and is the only province that provides health and social services as a “right” to its residents. Members of the various committees developed a broad perspective on social policy which came to include income security, manpower (vocational training and manpower centres), social services, housing and leisure activities. This led to the amalgamation of the Ministries of Health and of Welfare into the Ministry of Social Affairs and Health. A year later the province was divided into a network of twelve regions, each with a council with representation of the regional municipalities, regional socio-economic groups, universities and colleges, and the regional institutions (the well known CLSCs, social service centres, hospitals, and group homes).

While some other provinces have roughly analogous arrangements, none have made such an effort to integrate health and social service functions, and to institute this concept throughout the province. At the same time, implementation of the healthcare system exposed preexisting problems with the Code des Professions, and it was necessary to clarify and modernize the code; this task was included in the mandate of the Commission d'enquete. Finally, all practicing physicians had to choose to function either completely outside the government plan or completely within the plan.

The Outstanding Players

During the years of constant advocacy, the person who stands out
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CLAUDE CASTONGUAY (continued)

clearly for his commitment and leadership of the pro –public health care policy, is “Tommy” Douglas, NDP premier of Sask. for much of that period. Without the support of the Liberal minister of finance in Ottawa (Walter Gordon), and the unanticipated backing by Conservative Premier Frost of Ontario however, there is some doubt that Douglas alone would have been successful at that time. Nevertheless he is credited with being the prime mover and constant proponent of the public health care system which we now have. He has often been referred to as the father of Medicare.

However the perspective is different in Quebec, where the person considered to be responsible for Medicare is Claude Castonguay, a man whose career has included chair of several important committees, a short period as a member of the legislative assembly and as Minister of Health and Social Services, appointment to the Senate of Canada, president of a bank and of an insurance company. He has been consulted by virtually every Quebec commission dealing with health care. And his ideas have changed over time.

As chair of the Commission d’Enquete sur la Sante et le Bien-etre social he was charged with designing the administrative structure and function of a healthcare agency (Regie de l’assurance maladie du Quebec). The commissioners visited Saskatchewan and Alberta, the two provinces with most experience with healthcare legislation, as well as Sweden, United Kingdom, France and Belgium. Castonguay was able to retain the confidence of four prime ministers during the life of the commission despite fundamental differences in point of view: while Premiers

Johnson and Bertrand were essentially conservative and market oriented, Castonguay continued to develop the plans for a single-payer, government financed system with no fees or payment at the point of service. The commission agreed that this was the best way of assuring universal access to care, regardless of ability to pay.

But in the past 10 years he has shown a complete reversal of his earlier attitudes.

a] In 1996, when charged with developing a new pharmacare plan, Castonguay proposed a complex arrangement of annual premium, a deductible, and co-payments, with the end result that the greatest burden fell on the working poor and seniors on a low fixed income. This was despite much evidence that for the poor, there would frequently be a choice made between medication and food (or rent). Within a few years enough data were available to show that this indeed has happened.

b] He then endorsed the recommendations of the Clair Commission to establish public-private partnerships for hospital construction, regulating the use of pharmaceutical agents, etc.

c] Recently after several well-publicized speeches promoting a two-tier system, he was named chair of a new committee to study the future of Medicare in Quebec: the conclusion of the study is entirely predictable – direct involvement of the private, for-profit, sector is necessary to save the public system.

The reasons given for this about-face are essentially the ever-increasing costs of healthcare, and the desire to return freedom of choice

regarding payment for healthcare to the individual.

To support his first contention, he uses the same arguments that have been presented repeatedly; that they have been refuted repeatedly is simply ignored. [for example, figures for Total (public plus private) Expenditures are used to show the high cost of the public system; he continues, illogically, to express the expenditure as a percentage of the provincial budget while ignoring the self-inflicted reduction in revenue due to reduction in income tax; he selects figures from short intervals to calculate the long term trend of expenditure/GDP].

As for his second contention, he uses the philosophy of individual rights which underlies unfettered market economics as the moral high ground of protecting the rights of the individual. But if the majority of individuals in a community decide that it is in their interest to act together rather than as individuals to achieve a publicly-funded healthcare system (as they have done repeatedly), would he take the anti-democratic stance of refusing their right to do so ?

At present, Castonguay has the full backing of the premier of Quebec, the Minister of Health and Social Services, and the Minister of Finance. Indeed, the premier appears so intent on expanding the role of the private sector that he repeatedly refers to the Supreme Court decision in the Chaoulli case as an order to Quebec to create a place for the private sector, despite an open letter from representatives of the six provincial faculties of law that the judgment does not impose an outcome or a pathway to an outcome .

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PHARMACARE: EQUITY, EFFICIENCY AND EFFECTIVENESS. WE'VE WAITED LONG ENOUGH

Joel Lexchin

Canadians have been waiting for pharmacare since the early 1960s when it was proposed by the Royal Commission on Health Care. However, despite repeated promises in the ensuing decades from the National Forum on Health and even the Liberal party itself during the 1997 election, Pharmacare still remains beyond our grasp. As a result we have the situation where 3 percent of Canadians, or about one million people, are considered uninsured because they pay more than 4.5 percent of their gross family income for prescription drugs and an additional 3.3 million who pay 2.5-4.5 percent of their income are labeled underinsured (Applied Management in association with Fraser Group Tristat Resources 2000).

CLAUDE CASTONGUAY (continued)

What induces a man of Castonguay's stature, initially concerned with social justice, that is, fairness and equity in the distribution of social "goods" decide that "freedom of choice" is a higher priority even if the community doesn't agree? Following his resignation from the Legislative assembly he spent the remainder of his career in the corporate world; can the constant exposure to the atmosphere and culture of the corner office on the top floor be enough to wash empathy and compassion out of the cerebral cortex? ♦

The Ontario government estimates that 19 percent of the population or nearly 2.5 million people lack insurance (Ministry of Health and Long-Term Care 2006). According to a recently published study out of Toronto's Hospital for Sick Children, a significant number of children lack timely access to necessary medications because of economic problems (Ungar et al. 2003).

The poorest fifth of the Canadian population spends more money out-of-pocket on prescription drugs than the richest fifth (Lexchin 1996). For people over 65 it makes a significant difference which province you live in when it comes to drug therapy. A low income senior in Saskatchewan with average drug use in 1998 would have paid \$500 out-of-pocket but the same person with the same drug use in Ontario would pay less than one tenth that amount (Grootendorst et al. 2003).

Internationally, Canadian public spending on drugs as a percent of total drug costs or on a per capita basis ranks near the bottom of the list of industrialized countries. The only place that consistently has a worse record than Canada is the United States (Jacobzone 2000).

Proposals from Kirby (Standing Senate Committee on Social Affairs 2001) and Romanow (Commission on the Future of Health Care in Canada 2002) have abandoned the idea of first dollar universal drug coverage in favour of some form of catastrophic coverage. In the case of Kirby coverage would start once people had spent 3 percent of their annual income on prescription

medication; Romanow suggests a \$1500 deductible. In 2003, provincial First Ministers pledged "by the end of 2005/06, to ensure that Canadians, wherever they live, have reasonable access to catastrophic drug coverage" (Health Canada 2003). However, that pledge has now been superseded by the National Pharmaceutical Strategy and in its June 2006 report all that it could offer was a set of principles that had been developed for coverage and a recommendation for further study (Federal/Provincial/Territorial Ministerial Task Force 2006).

Catastrophic drug coverage, while better than nothing for those currently without any insurance, would still leave low-income people vulnerable to high drug costs. In Ontario, the minimum wage of \$8.00 per hour translates into an annual income of \$16,000. If Canada adopted the Kirby proposal then that minimum wage person would be spending about \$480 per year on drugs; a considerable portion of her disposable income after accounting for shelter and food.

On equity grounds alone, there is a strong argument for Pharmacare, but beyond equity Pharmacare will help Canada control rising prescription drug costs. Retail prescription drug costs are rising at about 8 – 10 percent per annum after controlling for inflation and since the late 1990s Canada has been paying more for medications than for doctors.

One of the main factors accounting for this continual inflation is the use of newer more expensive drugs in place of older, less expen-

PHARMACARE: EQUITY, EFFICIENCY AND EFFECTIVENESS. WE'VE WAITED LONG ENOUGH (continued)

sive products. For example, by 1998/99 over half of the \$1.9 billion being spent by the Ontario Drug Benefit Program was on drugs introduced since 1992/93 (Federal/Provincial/Territorial Working Group on Drug Prices 2000). An analysis done by Green Shield (2002), a non-profit insurance company found that the price of a prescription for generic drugs barely changed from 1997 while the price for one that contained new patented medications went up by 9 percent per annum.

Provincial drug plans have been largely attempting to deal with rising drug expenditures by shifting costs onto users of the system. This was the approach that Quebec used when it decided to expand its drug insurance system without increasing government expenditures. Prior to the change in the Quebec system people on social assistance were exempt from any copayments and seniors paid \$2.00 per prescription. After the change those on welfare had to pay up to \$50 per quarter and the elderly were subject to deductibles and copayments that ranged \$200 to \$925 per year.

These charges meant a drop in essential drug use of more than 9 percent for welfare recipients and just under 15 percent in the elderly and corresponding increases in hospitalizations, physician visits and trips to emergency departments (Tamblyn et al. 2001). (Quebec has recently eliminated the copayments for those on welfare.)

Encouraging the use of private drug insurance will also do little to either control costs or improve equity. Most private drug plans in Canada are much less aggressive in

cost control measures than public plans (Taylor 1996) and administrative costs in private plans run around 8 percent compared to 2-3 percent in large provincial plans (Palmer D'Angelo Consulting Inc. 1997).

Moreover, private insurance through the work place is a regressive way of providing benefits. Currently, the portion of insurance received through the workplace that is paid for by the employer is exempt from personal income tax. According to Stabile (2002) the value of the subsidy that an individual receives through private insurance is based on his/her marginal tax rate. In a progressive tax system, like the one that exists in Canada, that translates into higher subsidies for those earning higher incomes. In fact, people in the highest 20 percent income bracket receives a benefit more than three times greater than the lowest 20 percent.

Monopsony buying power, where a single buyer controls the bulk of the market, like that used in the Australian Pharmaceutical Benefits Scheme helps keep costs for individual drugs 9 percent lower than those in Canada (Productivity Commission 2001). Other measures like tendering for generic products available from multiple companies and cross price subsidization (requiring lower prices for already listed drugs in return for accepting new listings) that have cut the New Zealand drug budget by almost 50 percent (Pharmaceutical Management Agency 2006) stand little chance of success in a world of multiple payers.

Finally, Pharmacare has the potential to help improve the way that doctors prescribe.

Premarketing trials test drugs on selected groups of patients but when the products are released on the market they are the object of intense promotional pressure and as such often end up being prescribed to large numbers of patients who were excluded from the clinical trials. This heavy prescribing takes place long before the full safety profile of new drugs is known and therefore exposes patients to potentially serious problems. In the United States it's estimated that Vioxx caused an additional 88,000-140,000 excess cases of serious coronary artery disease in the U.S. in the five years it was on the market (Graham et al. 2005). New drugs not only pose safety problems but for the most part they do not offer any major new therapeutic benefits. Figures from the federal Patented Medicine Prices Review Board (2005) show that only slightly more than 10 percent of all new drugs are significantly better than existing medications that are generally much less expensive.

Economic incentives and disincentives can be used to limit prescribing of new drugs but once again these disincentives are only going to be successful when they apply to the majority of prescribing decisions. Furthermore, if government was paying the bulk of the drug costs it would probably have much more of an incentive to ensure appropriate use, if for no other reason than to keep costs down. In Australia, the federal government provides about \$25 million annually to the independent National Prescribing Service whose mission is to improve drug prescribing by doctors and drug use by consumers.

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PHARMACARE: EQUITY, EFFICIENCY AND EFFECTIVENESS. WE'VE WAITED LONG ENOUGH (continued)

The usual argument mounted against a first-dollar pharmacare system, similar to what already exists for doctors visits and hospitalizations, is that it is unaffordable. To begin with this line of reasoning simply ignores the reality that we are already paying for prescription drugs to the tune of almost \$18 billion per year for prescription drugs. The question is not can the country afford the cost but rather how will the cost be met.

Currently, government accounts for a little under half of all costs, private insurance covers 34 percent and the rest is paid out of pocket. If government were to pick up the entire tab then it is inevitable that public spending would increase, probably by about \$7.7 billion annually. However, even allowing for increased use of prescription drugs by groups now not covered at all or undercovered, total spending on medications would actually drop by between 9-10 percent because of lower administrative costs and lower prices that could be achieved through national bargaining power.

Right now we are funding prescription drugs the way that Americans fund their entire health care system. We have rejected the American approach for doctors and hospitals because we have recognized that it is inefficient and inequitable. It's time to reject that approach to paying for prescription drugs. Pharmacare makes sense on all three grounds – equity, economic efficiency and effective prescribing. It's time to stop waiting for it. ♦

This is an abbreviated version of the paper Joel Lexchin presented at the Regina SOS Medicare 2: Conference, May 3-4, 2007. For more information see www.healthcoalition.ca

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COMPLETING THE VISION: ACHIEVING THE SECOND STAGE OF MEDICARE

Michael Rachlis

Today all Canadians are concerned about the state of Medicare. Recent international surveys show that Canadians wait longer than most others for family doctor appointments, emergency room service, specialist appointments, and elective surgery.¹ The twenty to thirty percent of Canadians who never wanted Medicare now say, “We told you so. This government health plan wasn’t ever going to work.”

Few Canadians know that the original vision of Medicare went well beyond public payment for the old system. The original vision of Medicare included new ways of delivering care. But, as then Saskatchewan Premier Tommy Douglas realized in the 1950s, this vision would have to be implemented in two stages. Here’s how Tommy Douglas explained it to the SOS Medicare conference in November 1979:

I am concerned about Medicare – not its fundamental principles- but with the problems we knew would arise. Those of us who talked about Medicare back in the 1940’s, the 1950’s and the 1960’s kept reminding the public there were two phases to Medicare. The first was to remove the financial barrier between those who provide health care services and those who need them. We pointed out repeatedly that this phase was the easiest of the problems we would confront...

The phase number two would be the much more difficult one and that was to alter our delivery system to reduce costs and put an emphasis on preventative medicine....

This paper first outlines the original vision for Medicare and explains why we are still waiting for it.

Then the paper suggests a list of principles for the implementation of the Second Stage of Medicare. Finally, examples of successful policies and programs that follow from the principles are profiled.

This paper concludes that it is essential to complete the first stage of Medicare by insuring home care, long-term care, pharmaceuticals, and interdisciplinary primary health care. But, Medicare advocates must simultaneously campaign for the implementation of the Second Stage of Medicare.

Medicare’s original vision in Saskatchewan

Saskatchewan led the rest of the country and the continent with its health policy.² Before Tommy Douglas became premier in 1944, the province already had a thriving municipal doctor program, provided universal care for patients with tuberculosis, and had established Canada’s first cancer control agency. After his victory in 1944, Douglas appointed Dr. Henry Sigerist, an internationally known Johns Hopkins professor of medicine to review the province’s health system.³ Sigerist recommended the establishment of district health regions to focus on preventive medicine. The district would include hospital and medical care, diagnostics, public health, and home care. To ensure the focus was on prevention, Sigerist recommended that the medical officer of health head up the health region.

Saskatchewan established the Health Services Planning Commission to continue planning and facilitate im-

plementation of the Sigerist report’s conclusions. Southwestern Saskatchewan was keen to move and on January 1, 1946, the Swift Current Health Region was established, providing universal hospital and medical care.⁴

The Swift Current Region model doesn’t spread

However despite the popularity of the Swift Current plan with local doctors and the initial positive reviews from Canadian organized medicine, opposition from doctors in other parts of the province and country prevented the spread of the Swift Current model.⁵

Eventually the Saskatchewan provincial government, led by Douglas as Premier, moved ahead with Medicare’s first stage, providing insurance to people when they got sick. In 1947, Saskatchewan implemented universal hospital insurance and in 1962, medical insurance. However, over 90 per cent of the province’s doctors went on strike, refusing to see patients even in an emergency.⁶ Eventually, Saskatchewan’s doctors essentially settled for what the government had been offering.

However, in the longer-term, Canadian governments were collectively shaken by the bitter 1962 doctor’s strike and were loathe to have a repeat. As a result, Canadian governments did little to change the way health care services are organized and delivered until very recently. The federal government did implement a national hospital insurance plan in 1957 and a national medical insurance plan in 1968. But, in 1972 when a re-

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port prepared for the country's deputy ministers of health recommended a version of the Swift Current model, it was soundly rejected by organized medicine and not pursued by governments.

There were some new models of care developed based on group practice and integration of public health. The Saskatoon Community Clinic was founded by a community group during the 1962 doctors' strike and now employs 150 staff and provides medical services to 20,000 patients and community-based preventive services to thousands of others.⁷ A 1981 study of the Saskatoon Community Clinics found that the community clinic patients had 17% lower overall costs and 31% fewer days in hospital.⁵

In 1964 a Sault Ste. Marie Community Group led by the United Steelworkers of America opened the Group Health Centre.⁸ The centre now has over 60,000 patients, nearly 70 doctors, 110 nurses, and 50 other health professionals. Group Health, as it is called, has been a font of innovation for over forty years⁹ and has been cited for its innovative care in access and chronic disease management.^{10,11} Studies from the 1960s and '70s, found that the Sault Ste Marie Group Health Association Clinic had lower overall health care costs because they spent 20-25% fewer days in hospital.^{12,13,14}

In the United States so-called "prepaid group practice" developed in the early 20th century primarily to provide health care to workers in large construction projects such as the Grand Coulee Dam. Studies over the years have concluded that prepaid group practices such as the Group

Health Cooperative of Puget Sound and Kaiser-Permanente set standards of excellence for health care system performance. In the most expensive health services research project ever funded, the Rand health insurance study found the costs for Group Health Cooperative patients were 25% less than those seeing fee-for-service doctors — due almost entirely to the fact that Group Health patients spent 40 percent fewer days in hospital.^{15,16}

In general Medicare has been good for Canadians

The first stage of Medicare has been very good to Canadians. Up until the late 1950s, Canadians and Americans had similar health status and similar health care systems with similar costs. Now Canadians are healthier¹⁷ and spend much less on health care. Despite the world's highest health care spending, nearly 60 million Americans either have no insurance or live with someone who lacks coverage,¹⁸ and tens of millions have such bad coverage that health care bills bankrupt half a million every year.¹⁹

And, Medicare has been good for Canadian business by reducing manufacturers payroll costs by up to \$6 per hour per employee.²⁰ We have done well by adopting Douglas' first stage of Medicare. But as Douglas predicted our health system has developed problems by not implementing the Second Stage of Medicare.

But, Canada's health system has run into predictable problems because of the failure to implement the Second Stage of Medicare

When Canadians first started debating Medicare one hundred years ago, we were a young country and most health problems were acute. However, today our main health problems are chronic diseases in an aging population.^{21,22,23} And because Canadian physicians have not integrated their practices with each other or with the rest of the health system, Canadians with chronic diseases frequently develop complications which could have been prevented with better follow up. Canadian management of patients with chronic disease is poor internationally just slightly better than the US.^{24,25} And, most chronic diseases could be prevented altogether.^{26,27,28} If the potential for prevention could be translated into reality for these four conditions, approximately 2900 hospital beds could be freed up in Ontario alone.²⁹

Medicare's Achilles' heel: Long waits for care

Compared with other wealthy countries, Canada has some of the longest waits for primary health care, medical specialists, hospital emergency rooms, and elective surgery.³⁰ Douglas noted in his day that needless "ping-ponging" between different specialists and diagnostic tests caused many delays.³¹

"I have a good doctor and we're good friends. And we both laugh when we look at the system. He sends me off to see somebody to get some tests at the other end of town. I go over there and then come back, and they send the reports to him and he looks at them and sends me off some place else for some tests and they come back.

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Then he says that I had better see a specialist. And before I'm finished I've spent within a month, six days going to six different people and another six days going to have six different kinds of tests, all of which I could have had in a single clinic."

Now the waits are longer because there are more specialties, more tests available, and because modern practices won't allow patients into hospital just to have all their tests and consultations at once.³² Again, these problems are related to the failure to move to group medical practice and organize modern processes for patient flow. We're still using the pony express but expecting communication at the speed of light.

When care processes are updated using the original vision of Medicare, waits plummet. The Saskatoon Community Clinic sees their patients the day they want to be seen³³ and the Saskatchewan Health Quality Council has taken this innovation to 25% of the province's primary health care practices.³⁴ The Hamilton Shared Care Mental Health Program integrates 145 family doctors, 17 psychiatrists, 80 counsellors to provide primary health care-based mental health services to over 300,000 patients.^{35,36} The program increased the number of patients using mental health services by 1100% while simultaneously reducing referrals to the psychiatry specialty clinic by 70%.

Canadians should also have faster access to elective surgery. For example, the Alberta Bone and Joint Institute Pilot Project³⁷ reduced wait times for artificial joints from 19 months to less than 11 weeks, all the

way from family doctor referral right through to surgery. The key changes included creating orthopaedic surgery group practices.

When you put it all together, we shouldn't have to spend a lot more money in Canada to get some day access to primary health care, routine specialty care within one week, and elective surgery a month.

The Second Stage of Medicare is coming but can we wait?

We have known the broad brush strokes for the Second Stage of Medicare since at least Swift Current in 1945. The development of the quality agenda in health care has added a lot of detail to the sketch. And, there are more and more Canadian examples of these Second Stage programs with their attendant benefits to health and the health care system. If we could implement the Second Stage of Medicare we could improve the country's health, a lot, including the health of the people who provide care. While Medicare has problems, it's pretty clear that we can fix them all without charging clients or contracting out care to the lowest bidder.³⁸

But, while there have been many improvements in Medicare, the pace is slow and our public discourse is plagued by the endless debate about privatization. The media has a strong bias against "good news" so they provide almost no coverage of Second Stage reforms. Google records 300 times as many "hits" for Vancouver orthopedic surgeon Dr. Brian Day than the Alberta Bone and Joint Institute. Dr. Day's private clinic offers quicker artificial joint implants

for cash on the barrel. But he would have no customers if the Alberta Institute's pilot project were spread across the country.

Canada needs to complete Medicare's first stage by providing public coverage for pharmaceuticals, home care, and preventive dental services. But if we don't re-focus our health services on keeping people well, we will never be able to afford the First Stage. To quote Tommy Douglas:

"Only through the practice of preventive medicine will we keep the costs from becoming so excessive that the public will decide that Medicare is not in the best interests of the people of the country."♦

This is an abbreviated version of the paper presented by Michael Rachlis to the SOS Medicare Conference in Regina, May 3-4, 2007.

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THE PRINCIPLES FOR THE SECOND STAGE OF MEDICARE

Essential Principles – What we Want

1. Population Health Focus

There should be a determined effort to continuously improve the overall health of the population.

2. Equitable

There should be continuing efforts to reduce disparities in the health of those groups who may be disadvantaged by social or economic status, age, gender, ethnicity, geography, or language.

3. Client-Centred

Client-centred care respects individuality, ethnicity, dignity, privacy, and information needs of each clients and the client's family. That respect should pervade the health system. Clients should be in control of their own care.

4. Effective

The best science and evidence should be used to ensure care is the best, most appropriate possible. Innovations should also be based on best evidence, whether they are new ways of coordinating care, preventing disease, delivering service, or using technology.

5. Accessible

Clients in need should get timely care in the most appropriate setting. The system should continuously reduce waits and delays.

6. Safe

People should not be harmed by the care that is intended to help them. The system should monitor and continuously reduce adverse events.

Instrumental Principles – How we will get there

7. Efficient

There should be continuing efforts to reduce waste, including waste of supplies, equipment, time, ideas, and health information.

8. Accountable

The system should be highly accountable to clients, their families, and funders. There should be clear quality objectives for all health service providers. The objectives and funding should be aligned at the provincial, regional, and local levels to ensure clients and families experience fully integrated care.

9. Appropriately resourced

The health system should plan for appropriately trained human resources; provide a safe and satisfying environment for their work and provide sufficient facilities, instruments, and technology to support productive and effective care.

10. Non-Profit delivered

Health care is fundamentally different from commercial good and services. Markets simply are not designed to deal effectively with health care, which is a social function. Health care providers provide the best care when they work cooperatively.

SAFER VISIT TO DEMOCRATIC REPUBLIC OF THE CONGO

Brad MacIntosh

Lake Kivu is a large body of water that separates eastern Democratic Republic of the Congo (DRC) and Rwanda. The view from above is spectacular, with rolling hills and forests so thick and green that it is hard to believe that this is one of the most dangerous places in the world. After a long flight over North Africa, Ethiopia, Kenya and into sub-Saharan Africa, my feet were planted on Rwandan soil and I knew that I was about to embark on a life-altering experience.

As Stephen Lewis describes so elegantly, once you set foot on Africa, it gets into your blood and never leaves you. I could feel my heart swell. The euphoria did not last long, however, as I was startled back into reality. The first man that I made eye contact was a tall and slender Rwandan customs official with a stoic face. My eyes moved down and I quickly realized that he had survived the genocide. He waved us through, towards customs at the Kigali airport, with his left hand. His right hand had been amputated at the level of the wrist. No doubt it was his dominant hand that had been cut off during the war, a common maiming tactic.

I was one of four Canadian SAFER researchers en route to Bukavu, South Kivu, a large city near the Rwandan border. Our objective was to review the gynecological patient records for the year 2006 at the Panzi hospital to document the prevalence and treatment of sexual violence. DRC is a country that is twice the size of Ontario and the unfortunate host for Africa's first and on-going World War.

The scene of one of the worst humanitarian crises, with estimates for the conflict-related death toll at approximately 4 million people, it is here that rape is used systematically as a weapon of war.

Before starting our mission, we had a layover in Kigali, so we decided to tour around this African city on the rise (Rwanda is heavily supported by international funds and prospering as a result) with President Paul Kagame maintaining a strict and militarized state. We visited the Hotel Mille Colline, the famous "Hotel Rwanda", which meant a lot to me because it was also the site for Gil Courtemanche's breath-taking novel "A Sunday by the Pool in Kigali".

Next we visited the Genocide Museum in the outskirts of the city. It is a remarkable exhibit with beautifully manicured grounds. My colleague Olivier Couture pointed out the west's ability to create inspiring museums and memorials *after* an African war or conflict is over. His observation left me feeling with a level of shame that I had never experienced before because it was to true in this case.

If I could describe my trip to Rwanda and DRC it would be an expedition of emotional extremes. We spent the day in Kigali with our driver, Ian, a handsome and intelligent young Rwandan man. The mood was friendly and we began to ask him some questions about his past and it was then that he told us that he was a child soldier in the Rwandan army at the age of 15 – 16, given the duty of protecting the city while the men fought in the hills. The genocide in Rwanda not only killed hundreds of thousands but also robbed young people like Ian of their innocence and childhood.

The next day we were scheduled to fly from Kigali to Kamembe, right on the DRC border. The Public Relations Officer for Panzi Hospital, Eraston Bengé, greeted us and he was all smiles. With his help we sailed through the road blocks at customs and no doubt we owe our safe passage to his abilities and skill. But there could

be no mistaking the DRC border. It can safely be said that the end of the Rwandan genocide was the starting point for the conflict in DRC. We were in the heart of darkness.

It is a good thing that I reserved judgement, though, not letting fear take over, because the Congolese we met were warm, sincere and incredible people. Naturally I wondered where are the blood-thirsty, mad and drugged rapists? In the first six months of 2007, a period that can be described as "violent peace", the U.N. Mission in DRC (MONUC) reported 4,500 new rape cases in the province of South Kivu alone. With time we learned that the perpetrators are not likely to be in the streets of Bukavu, but live an opportunistic and terrorizing existence in the hills and National Parks. Slavery, stealing and raping are integral parts of the underground economy that involves the trade of guns and precious minerals, like Coltan and diamonds. Whole villages would be under control of a rebel group such as the *interahamwe*. From testimonies of rape survivors we learned that in rural eastern DRC, women would be sex slaves after witnessing the assassination of their husbands and children.

We arrived in Bukavu during a relatively peaceful time: U.N. forces were present in the city by the thousands. Each morning we would see hundreds of women marching in a line with a massive load of material over their back. Held by a strap that went over the shoulders and anchored at the top of the head, it was clear that the women of Congo were shouldering a disproportionate load. Men simply don't do this kind of work, we were told.

It was with this vision each morning that I began to understand the massive number of prolapsed

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SAFER VISIT (continued)

uterus cases at Panzi Hospital. Gynecological surgeons at the Panzi Hospital perform dozens of hysterectomies each month on women whose uteruses have prolapsed, in extreme cases externally protruding. Dr. Justin Lubala, a consultant to SAFER and surgeon at Panzi Hospital, explained that the combination of malnutrition, eight to twelve pregnancies over a life-

time, old age and the long hours of transporting twenty to fifty pound loads on the back wears down a woman's body to the point that her insides fall out. It was clear to me that women are suffering both acutely, as is the case when a woman is left with a fistula due to the trauma of a gang rape, and they are suffering systematically, due to egregious gender disparity.

Recounting these stories now in retrospect may appear pessimistic and dark, but the feelings I take away from my journey into eastern DRC couldn't be further from the truth. In three short weeks we visited several places and met numerous people that were changing DRC for the better on a daily basis. I left feeling that answers exist on the ground, how can I best support them?

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