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# Medical Reform

Newsletter of the Medical Reform Group

Issue 147

Volume 28, Number 4

Spring, 2009

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## IT'S TIME TO ACT—STUDENTS FOR MEDICARE ORGANIZE TO FILL GAPS IN THEIR EDUCATION

*Janet Maher with Malika Sharma*

Ever wondered why the advocates seem to be getting grayer by the year? Is the health care system really at risk or are old-timers just nostalgic for some idealized good old days? Encouraged by outreach workers at the Ontario Health Coalition, a group of Ontario medical, nursing, and allied health students weren't able to answer these questions very satisfactorily at the beginning of their last school year, and found few answers in their classes and books.

And so they took on an attempt at self-education which resulted in a day-long conference, Saturday, March 28<sup>th</sup>. The day featured a mix of opportunities to learn from veterans and peers, to build skills and work together to defend and enhance the only health care system most of them have ever known.

The day opened with researcher Pat Armstrong highlighting the history of medicare. Her presentation reviewed the original vision for medicare and the context for policy making over nearly 50 years, along with an analysis of some of the continuing pressure points.

Armstrong noted that where we are now is the result of a partic-

ular history and evolution of health care in Canada. This started with public coverage of physician and hospital care, and anticipated incremental expansion to cover drugs, dental services, long-term and home and community care as resources permitted.

She described the public debate around the Canada Health Act as an attempt to enhance public accountability for an increasing public investment. While it represented well the consensus of the day, however, the Act did not really challenge the reluctance of provinces to submit to federal monitoring.

The other keynote speaker of the morning was Gordon Guyatt, who focused on the little-understood and often overlooked distinction between private and public funding in for profit and not for profit delivery settings, and then examined some common myths and their basis in the evidence.

Health care are costs out of control: this conclusion is impossible sustain if we look at the evidence. Based on Canadian reports to the Organization for Economic Cooperation and Development, while total health spending has increased from 7 to 10 per cent of Gross Domestic Product over the last 30 years, public spending on health has been much more modest, increasing from approximately 5.5 per cent in 1975 to just under 7 per cent in 2008. While health care accounted for 30 per cent of the Ontario budget in 1980, this had increased to 45 per cent by 2004.

Guyatt showed how this conclusion is the result not of an increase in spending on health care, but of a declining public role in education, housing and other types of urban infrastructure and a real decline in income security for the most vulnerable.

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

Spring, 2009

Volume 28, No. 4 Issue 147

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**MEDICAL REFORM** is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at \$60 per year. Arrangements may be made to purchase multiple copies or annual subscriptions.

Articles and letters on health-related issues are welcome--please forward electronically to [medicalreform@sympatico.ca](mailto:medicalreform@sympatico.ca).

Contact us at:

**MEDICAL REFORM**

Box 40074, RPO Marlee  
Toronto, Ontario M6B 4K4.  
Telephone: (416) 787-5246  
Fax: (416) 352-1454  
E-mail: [medicalreform@sympatico.ca](mailto:medicalreform@sympatico.ca)

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Editorial committee this issue: Janet Maher, Malika Sharma

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*

I am sure you will agree with me that the energy and action spawned over the past year by the enterprising group of health sciences students and residents featured in our lead article this issue as the Students for Medicare, should be an example to our political leaders, both federal and provincial.

With few resources beyond their own critique of the gaps in their post-secondary education as future health professionals, a core group of about a dozen designed a program, invited and briefed guest speakers and workshop facilitators, and brought together nearly 200 of their colleagues for a day of learning and planning for action. They produced a short video on activist Mimi Divinsky from archives to complement the tribute on behalf of the Steering Committee from Rosana Pellizzari.

Since our last newsletter, we have had both federal and Ontario budgets, and both regrettably seem to have fallen far short of our expectations. Federal finance minister Flaherty grudgingly acknowledged the likely impacts of the economic downturn with the minimum stimulus package, and it remains to be seen how much of the package will actually be got to the people who need it most--given the eligibility conditions requiring financial matches by municipal governments and non-profit entities and the failure to address the impacts of wholesale job losses, particularly in the manufacturing sector.

True to form, the Conservatives favoured tax cuts over serious job creation, and to date, have done little to address the fact that only one in three Canadians who have contributed

to Employment Insurance can draw on it if they lose their jobs.

The response of the Ontario government was different only in degree. Beyond its December 2008 commitments to poverty reduction, and an early announcement that they would advance their promised Ontario Child Benefit by a year, the Ontario budget was also a big disappointment.

As they have done in each of their Budgets, the Liberals offered a grudging 2 per cent increase to social assistance and disability recipients, who lost over 20 percent at one time at the hands of the Harris government in 1996. What that means is that when inflation over the intervening 13 years is taken into account the 6 per cent offered by the Liberals still leaves recipients with 50 per cent less purchasing power than they had in 1996. The provincial package of tax cuts, mainly planned for 2010, will barely mute the effect of harmonizing the provincial sales tax on goods with the federal Goods and Services Tax.

The other feature article this issue is an interview with Steering Committee member Rosana Pellizzari who moved to Peterborough last year to be their Medical Office of Health. From all accounts, the move has given her renewed energy for advocacy. Stay tuned! ♦

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## IT'S TIME TO ACT—STUDENTS FOR MEDICARE ORGANIZE TO FILL GAPS IN THEIR EDUCATION (continued)

After reviewing Canada's performance relative to other countries, Guyatt set out a short list of options for ensuring the sustainability of public health care in the following terms:

- ◆ Wait time initiatives: centralization of wait lists and integration of care with specialized surgical facilities
- ◆ Interprofessional care: ensure the right provider in the right place at the right time
- ◆ Improved chronic care management with self-care, home care and community-based care
- ◆ Implementation of the electronic health record to minimize duplication and enhance safety and quality.

Canadian Doctors for Medicare presenters Irfan Dhalla and Danielle Martin raised questions about the current fascination with the lessons of Europe and the rest of the world, and concluded that most of them tell at best only part of the story. They noted that while Japan exceeds Canada in life expectancy and certain indicators (like health care expenditures and the availability of certain kinds of technology like MRI and CT scanners) make the comparison attractive, it is not clear that we would want to import a system where little attention is paid to the accreditation or facilities or personnel and where physicians receive incentives for each drug prescribed.

There are of course lessons to be learned elsewhere. What most European countries do well is integrate drug coverage in their public programs, and pay greater attention to the social determinants of health,

which facilitates more generous social supports for residents.

After lunch, students had the choice of a range of skill-building workshops, facilitated by allies in the Association of Ontario Health Centres, the Ontario Health Coalition, the Ontario Nurses' Association and the MRG. Here, students had the opportunity to develop and hone skills which would give them confidence as advocates—from organizing lobby and media campaigns, understanding the multidisciplinary model of community health centres or the urgency for a national pharmacare strategy.

A highlight of the day was a tribute to long-time MRG steering committee member Mimi Divinsky by one of her colleagues, Rosana Pellizzari. Pellizzari introduced a short video on Mimi Divinsky, focusing primarily on her work with the Medical Reform Group and her anti-poverty work over the years. She then presented the students with the proceeds of a special appeal to MRG members.

The day ended with a plenary panel on future directions, featuring CMA president-elect Dr. Jeff Turnbull, Executive Director of the Registered Nurses' Association of Ontario Doris Grinspun, Director of the Ontario Health Coalition Natalie Mehra, and nursing student Sarah Reaburn.

Turnbull began by noting that he believes he represents an opinion in Ontario that there is a desperate need for meaningful change in the way medical services are delivered—and that Ontarians want to see that change implemented in the context of publicly funded medicare. He

spoke about his own history as an international volunteer and as an advocate for homeless and marginalized in Ottawa. He urged the students to focus on solutions to wait times and investments in long term care and home care.

Like the morning speakers, Doris Grinspun urged students to recognize the effectiveness of publicly funded health care in Canada, where most health indicators, such as life expectancy and infant mortality were consistently better than in the US where costs were consistently close to 50 per cent higher. She spoke passionately about the role of nurses in community and preventive care summarized some recent RNAO campaigns as well the recent announcement of Ontario's first Nurse Practitioner-led clinics.

Natalie Mehra took advantage of her panel time to summarize the themes of the Ontario Health Coalition's current campaigns for the extension and enhancement of not for profit care and against hospital cuts which appear to rival those of the Harris hospital restructuring of the 1990s. She pointed to some very real threats not only to high quality public health care in our province, but also to the gradual and piecemeal erosion of democratic control of our institutions, and noted the opportunities for student involvement in the future of medicare.

Sarah Reaburn, a third year nursing student at Ryerson University provided perhaps the most poignant testimonial at the end of the day, focusing on the gaps in her education. An excerpt follows with her permission:

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## IT'S TIME TO ACT—STUDENTS FOR MEDICARE ORGANIZE TO FILL GAPS IN THEIR EDUCATION (continued)

I can only speak for my personal education experience so far. In regards to Medicare, the formal education I have received on the topic of our health system has been absolutely minimal. The education I have received has been from community forums, panels, and from leaders like Doris and Natalie...

It is to the credit of organizations like the RNAO, the OHC, the Medical Reform Group and Doctors for Medicare that many of the students here today have been able to learn the importance of Medicare not only to our professions but most importantly to our patients.

In three years of school, the great Medicare debate has only surfaced twice formally, and that is exactly how it has surfaced every time—as a debate about private versus public, rather than as exploration of Medicare's merits and the needs for innovation of our public system. Instead of being a focused discussion on how medicare works, it is chronically discussed as a debate to privatize or not to privatize...

Now this trend reflects the reality that more and more of our public services are being privatized—universities included. We have seen the impact of the increasing privatization of our universities, and how this has led to decreased access to education, and I would argue decreased quality of our educational experience as a whole.

The slow erosion of public funding for universities has resulted in increased tuition fees, and

therefore higher education is being accessed more and more by those privileged with wealth. As far as social transfers go, education and health care are the two most significant social transfers of wealth..

The fact that we are seeing education being provided more and more only to the rich can be used to explain this ever growing divide between the rich and the poor. So what about our health care? Will we go there too? I would like to think not...

In our training as nurses or doctors, there are few critical situations where we as students are so encouraged to question the prevailing wisdom and practice. Evidence-based, tried, tested and true interventions for care are used. Nothing is ever perfect but we do the best with what we have, and we innovate to make it better. We don't give up when someone's life is on the line.

It is fair to say that millions of lives are on the line, the longer we tolerate the privatization debate in our hospitals, in our communities, amongst our professions and within our educational institutions. Medicare is prevailing wisdom and good evidence-based practice. It is what patients across Canada have indicated they want.

The more time we spend deliberating about whether to save it or not, the less time we have to act on improving it. And then in the meantime, fabricated crises such as wait times, lack of health care providers and hospital closures due to inadequate

funding via inadequate budgets as we saw this week at Queens Park...

We can no longer tolerate discussions in our institutions about furthering the two tier agenda of corporations and governments. Instead we must use the time, and the connections and the great minds especially in our educational institutions to discuss how it is that we are going to strengthen and improve Medicare-NOT whether we should dismantle it.

So what does that mean practically, for students? We absolutely need to challenge our schools to shift the current discourse around medicare from that of discussing the market logic of privatization to focusing on its destructive effects on patient care.

I would challenge those of you in nursing, social work, medicine and midwifery to have your schools take a formal position on public health care, as has the RNAO, ONA, the MRG, the OHC. Also, I would ask all the students here today to take opportunities in classes to broach the subject of Medicare as often as possible. Direct your own curricula by bringing the subject to the classroom, knowing the myths to bust, and then busting them.

All of my rhetoric around debates is not to say that I do not believe that there should be debate in our classrooms. What I believe is that we, as a student movement, have to shift the focus of that debate from the ques-

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# IT'S TIME TO ACT—STUDENTS FOR MEDICARE ORGANIZE TO FILL GAPS IN THEIR EDUCATION (continued)

tion of “Should we keep medicare?” to that of “How are we all going to work together to transform medicare to an even better system than it already is?”

Within our practice setting we are asked to consider what truly client centred care looks like and

engage in it. As student professionals, I am asking you to think about what truly patient centred education looks like, and engage your teachers, your fellow students and your curriculum in it.

Patient centred education must include Medicare and so this is a

call to Action. And I look forward to working with all of you in building a stronger public health care system. ♦

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## PROVINCIAL BUDGET

*Janet Maher*

The Ontario Alternative Budget group have been monitoring both the federal and provincial budget processes for some years, and followed 2009 with perhaps more interest than previous years in view of the economic downturn. So it was hardly surprising that Ontarians had high expectations of their government—expectations largely dashed.

### **Context for the 2009 budget**

As the extent of the downturn began to become clear in the fall of 2008 and Ontario Finance Minister Duncan followed his federal counterpart with an announcement anticipating a ‘small’ deficit of perhaps \$500 million last November, policy analyst Hugh Mackenzie began by urging the province to avoid a structural deficit. In particular Mackenzie’s advice was to maintain public services and infrastructure spending and not succumbing to the temptation to cut taxes, as urged by the federal government.

Policy analyst John Stapleton drew some complementary lessons in a brief prepared for the Canadian

Centre for Policy Alternatives, noting that by February, 2009, the crash was already worse than it ever got in 1929.

Stapleton’s prescription: wholesale reconfiguration of income security measures to cushion the impacts for the most vulnerable. This would include establishing a floor for benefits for all of \$1,000 a month, and increasing disability benefits to the current floor for seniors of \$15,600 annually.

This would be achieved by a series of measures basically coordinating existing benefits. Stapleton’s recommendations are to amend Employment Insurance to lower the entrance requirement for all to 360 hours in the preceding year, and convert all the current non-refundable tax credits to a single refundable credit of up to \$2,500. Additional working income, shelter benefits and similar allowances in addition to the existing social assistance allowances would bring the base level for a single person under 65 to \$1,000.

### **Ontario Budget 2009**

Highlights of the Ontario budget, released March 26<sup>th</sup>, focused mainly on infrastructure spending and advancing the government’s commitments to reducing child poverty. Measures include:

- ♦ A two year investment of \$32.5 billion to improve hospitals, roads, social housing and schools and support 300,000 jobs
- ♦ New skills and literacy training of up to \$700 million
- ♦ An Emerging Technologies Fund of \$250 million and \$10 million annually for the next 5 years for a Smart Electricity Grid
- ♦ Nearly \$500 million in research, development and innovation in priority sectors
- ♦ Increased incentives for apprenticeship completion with a new training tax credit
- ♦ A three-year commitment to economic development in agriculture, forestry and mining of \$130 million
- ♦ An increase in the Ontario Child Benefit from \$600 to \$1,100 from July 2009

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## PROVINCIAL BUDGET (continued)

- ◆ Doubling of the Senior Homeowners Property Tax credit to \$500 annually for eligible seniors
- ◆ An increase of 2 per cent in Ontario Works and Ontario Disability Support Program payments

On the revenue side, an improvement in sales tax credits and a cut in the lowest personal income tax rate are expected to reduce the tax burden of nearly an additional 200,000 Ontarians to zero. However, the main government initiative on the revenue side was to prepare for the Harmonized Sales Tax to be implemented July 1, 2010—and which will subject to provincial sales tax many goods and services previously exempt.

According to the Conference Board of Canada, the harmonization

should add \$2 billion to provincial tax revenues in the first year and more in subsequent years. To defuse some of the anticipated backlash to this measure, the government proposed additional low income measures and cuts in several corporate tax provisions.

### **Ontario Alternate Budget Response**

The day following the provincial budget release, Mackenzie released an analysis which he termed ‘hit and miss’.<sup>2</sup> As Mackenzie notes, the stimulus was significantly better than what was offered by the federal government in January, but still does nothing to support Ontarians who can’t collect Employment Insurance.

It also left open the question of assisting municipalities and other transfer payment agencies to meet the

infrastructure matches required by the federal stimulus program.

Mackenzie expresses scepticism at the stimulative impacts anticipated by the province because their preferred method of delivery is through tax cuts rather than spending, because the effect of tax cuts is cumulative and will basically slow recovery, without providing as much relief to the hardest-hit as to the corporate sector. While Mackenzie acknowledges the harmonization proposal makes economic sense, and that the proposed low income payments will protect the most vulnerable to an extent, he questions the proposed corporate tax adjustments which will have the effect of compounding the benefits to corporations of the sales tax harmonization. ◆

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## BILL 152 AND THE ONTARIO GOVERNMENT COMMITMENT TO A TRANSPARENT POVERTY REDUCTION PROCESS

*Janet Maher*

As we reported last issue, the McGuinty government has responded to public pressure to honour its election commitments to begin poverty reduction in earnest. For most of 2008, the cabinet committee on poverty reduction, headed by Minister Deb Matthews, sought community input on a strategy which was released on December 4<sup>th</sup>. As we noted then, the plan is a first for the province in that it formalizes the commitment, the 25 in 5 Network for

Poverty Reduction has continued to maintain the pressure.

In the first quarter of 2009, advocates focused on securing a recognition of the need identified in the form of a down payment in the 2009 budget. Acknowledging the findings of groups including Health Providers Against Poverty, the Ontario Association of Food Banks and the Association of Local Public Health Agencies about the impossibility of meeting local guidelines for nutritious eating for recipients of social assist-

ance, the coalition led a campaign to add a nutritious food supplement of \$100 monthly to adult allowances.

The Medical Reform Group, and others, maintained the pressure in individual MPP lobbies and letter writing campaigns. See our March 16<sup>th</sup> letter elsewhere in this issue.

In early March, the province tabled Bill 152, An Act respecting a long-term strategy to reduce poverty in Ontario, intended to address the government’s commitment to legislate poverty reduction as one of their

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# BILL 152 AND THE ONTARIO GOVERNMENT COMMITMENT TO A TRANSPARENT POVERTY REDUCTION PROCESS

## (continued)

priorities. The legislative committee of 25 in 5 undertook an assessment and consultation on this framework legislation and prepared notes for a draft brief. As with other government poverty reduction activities, the coalition has some significant concerns at the weakness of the legislative proposal—and the limited opportunities provided for debate on the bill—2 afternoons in mid-April.

The Medical Reform Group submitted a brief on Bill 152, using the 25 in 5 analysis, with the following objectives:

- ◆ To integrate the goal of a poverty-free Ontario in the preamble and vision of the legislation
- ◆ To include the elimination of poverty among adults as well as children
- ◆ To provide for explicit poverty reduction targets and timelines in the legislation
- ◆ To enhance public accountability by providing for an independent review to be tabled and debated in the legislature

As we go to press, we learned that Bill 152 has passed second reading with some wins and some losses. According to colleague Greg deGroot Magetti of the Mennonite Central Committee who has been guiding the Bill 152 legislative process for the 25 in 5 Network, amendments that were accepted included:

- ◆ Poverty reduction strategies will be guided by a vision that reflects Ontario's aspiration to be a leading jurisdiction in reducing poverty.

- ◆ Recognition that adult poverty, as well as the poverty of children and families must be tackled by poverty reduction strategies.

- ◆ A fixed date, March 31 of the following year, is established for the annual report to be laid before the Legislative Assembly.

- ◆ Stronger language regarding the significance of discrimination on the grounds of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability and the need for particular attention to be paid to the barriers faced by these groups.

- ◆ Women are now included in the list of groups at heightened risk of experiencing poverty.

- ◆ Stronger language to support the involvement of Ontarians, especially people living in poverty, in the design and implementation of poverty reduction strategies.

- ◆ Recognition of the significance of the third sector in poverty reduction work.

- ◆ Stronger language regarding the indicators to be used to measure poverty specifies that determinants of poverty include but are not limited to income, education, health, housing and standard of living.

- ◆ Stronger language regarding the individuals and groups to be consulted with by the Minister on a regular basis states: "The individuals and groups to be consulted by the Minister must include

representatives of people at heightened risk of poverty including immigrants, women, single mothers, people with disabilities, aboriginal peoples and racialized groups."

However, not all the coalition's recommendations were accepted.

In particular, we will not see:

- ◆ A vision of a poverty-free Ontario
- ◆ An independent body to review and assess progress on poverty reduction.
- ◆ A clause that would require Ontario's laws, policies and practices to be consistent with the principles outlined in the legislation.
- ◆ Recognition that strengthening Ontario's human rights laws and the enforcement system is essential to the reduction of poverty.
- ◆ A clause requiring targets to represent a "substantive" reduction in poverty.

The week before the budget was to be delivered to the legislature, the provincial treasurer announced that the government would be advancing its commitment to increase the Ontario Child Benefit by one year, nearly doubling the current maximum of \$600—by July 2009 rather than 2010 as originally expected.

By comparison, much of the rest of the March 26<sup>th</sup> budget was a serious letdown. Beyond the child benefit increase, the budget provided for a 2 per cent increase in social assistance and disability allowances. Other budget initiatives will provide

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# MEMBER PROFILE: ROSANA PELLIZZARI, COMMUNITY MEDICINE SPECIALIST

*Janet Maber, interviewer, spoke recently with one of the most active steering committee members on her recent career change.*

**O**ur readers have heard a little less from you than in the past. Where have you been?

I think my demise in the MRG probably began with my first Medical Officer of Health posting in Stratford in 2004. I did that for almost three years, commuting out to Perth County on Monday mornings and returning to Toronto for the weekends. That made it almost impossible for me to get to Steering Committee meetings.

The role of the Medical Officer of Health includes advocacy for healthy public policy and I put me in the public eye in a way that Family Medicine had not. It became more and more difficult to speak publicly as an MRG spokesperson, since I was now a public figure, reporting to a Board of Health, with 24x7 responsibilities.

So, that explains why I faded somewhat into the background. I was able to re-immense myself for the short time that I was back in Toronto as Associate MOH and Director of Planning and Policy for Toronto Public Health, but once I began my new assignment in Peterborough as MOH here, I once again found myself in a supporting, rather than starring role.

I've been in Peterborough now for about 9 months: long enough to start to feel at home in this lovely mix of urban, rural and First Nations communities. And I am finding that advocacy on the social determinants of health has consumed most of my energy.

**Why did you leave Family Medicine? Have you had second thoughts?**

I was always attracted to population health and had a tough time deciding between family medicine and public health as a Resident at McMaster. I crafted a third year of training to allow me to do public health, women's health and obstetrics, and then chose to stay in Family Medicine in a community health centre setting. And for 13 years, that was wonderful and fulfilling.

But I had always "played" at public health on the side. I applied for a provincial appointment to the City of York's Board of Health and eventually went on to chair it. I was Chair at the time that the pre-amalgamated Toronto attempted to introduce smoke-free bylaws and I still carry the scars of that battle!

We lost, the first time around, but learned some very important lessons, such as "never introduce a smoking by-law in January". The next time we tried, we did it in the summer so that smokers could go outside, and we had cultivated some important allies on the restaurant side. By that time, Sheela Basrur was Toronto's MOH. Sheela was a powerful role model and an inspiration for me.

When I noticed an ad by the Ministry of Health, looking for physicians willing to train in Community Medicine in order to fill MOH vacancies, I jumped. That opportunity allowed me to get the training and the academic credentials that I felt I had been missing. It allowed me to fill a need in the province. And it may

have filled some of the emptiness of the nest at the time, since both of my children were off at university.

I miss my patients terribly. When I run into them, we often hug and cry. It is like meeting old friends – we share a special bond. That experience is hard to replace. But I try to keep up my clinical skills by working in our sexual health clinics. I still enjoy the personal interaction and I learn from each relationship with a patient. I find that my years in Family Medicine are a bonus in what they have taught me and what I can bring to this new role.

**You've been in three different health units around southern Ontario since 2004. Can you tell us what you have learned?**

I have learned a great deal about what I need for balance and what I enjoy doing most. I have learned that there are lots of wonderful and dedicated activists out there, in different communities, wearing different hats. I have learned the importance of listening and of team building.

I came into public health at such a critical and fascinating time. West Nile Virus arrived as I started my new career. SARS happened in my first year of Community Medicine residency. My first night on call as Associate Medical Officer of Health in Peel was the night of the August 2003 black-out. And then, in 2004, the province announced "Operation Health Protection" – its plan to reinvest in public health, strengthen the mandate and build the new

*(continued on page 9)*

# MEMBER PROFILE: ROSANA PELLIZZARI, COMMUNITY MEDICINE SPECIALIST (continued)

Agency for Health Protection and Promotion. Many of us lobbied hard to get the social determinants of health embedded into our mandate – we won a partial victory. And I am already seeing the difference. Here in Peterborough, I chair the Community Food Network that is part of the Poverty Reduction work, spearheaded by the Mayor.

I think I have had a more intimate look at policy-making, and certainly understand it at the municipal level better than I did before. I have had to understand and interpret the scientific literature on a number of issues where there isn't strong evidence, or there is conflicting evidence. I have learned about emergency response and risk communications.

I know what Incident Management System is and I enjoy making decisions in a crisis. I am learning more about how to influence provincial policy, although my MRG work was a great formation for that. I am using all of the knowledge I acquired as an MRG member, a CHC advocate, a youth worker, a literacy teacher, and a physician in a context that is broader even than family medicine.

I am learning every day, in my new community and my new job. Right now, I am reading John Ralston Saul's "A Fair Country" and learning that Canada is a Metis nation, influenced very deeply by our aboriginal roots.

## ***Is there room for a larger or stronger role for public health in addressing some of the pressure?***

I am assuming that your question relates to the pressure on the

acute care system? Our recent success with tobacco illustrates that public health can make a difference: tobacco is still our leading cause of preventable illness and death, but we are turning that around.

Health promoting built environments that support more active living can influence healthy weights. Many injuries can be prevented. We know that inequities in health outcomes can be addressed by healthy social policies that distribute wealth, promote inclusion, provide affordable housing, promote access to post-secondary education and create healthy environments.

Public Health had a new mandate in Ontario. We now have Public Health Standards that articulate a clearer role for the sector. I am hoping that, with our new mandate, we can effectively insert ourselves into new dialogues such as urban planning and environmental protection.

I still think that primary care is the foundation for the health care system. I've seen improvements in primary care in this province with the expansion of Community Health Centres and the creation of Family Health Networks. I still would like to see more CHCs and sure wish that we had one in Peterborough.

## ***If you were in charge of Ontario right now, what do you think you could/would do to address health access and equity?***

Is there any way we can make the federal government put the money back into early childhood education (universal daycare)?

Ontario needs to get serious about its poverty reduction plan.

We could learn a great deal from Quebec, as a province that has been serious about its children, about poverty reduction and about healthy public policy. We could start by increasing social assistance rates and investing in our most vulnerable sectors of our population. The minimum wage should be a living wage. Many of us have been advocating for an immediate \$100 monthly Healthy Food supplement for social assistance recipients to allow them to buy food. We know that those incomes are not adequate to support a healthy diet. I would ensure that the province set targets for poverty reduction and then met them.

## ***What's next?***

Africa? I'm still keen to get back to international work, and hope to do that some day. It is sometimes difficult to focus on problems here that pale in comparison to the hardships, violence, and suffering that occurs daily in many parts of the world. I would welcome the opportunity to volunteer or work outside of Canada again. ♦

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# UPDATE ON SPECIAL DIET

Janet Maher

As members will be aware, some Ontario providers put considerable energy between 2005 and 2007 into assessing social assistance recipients for the Special Diet, a series of allowances which recognized the role of good nutrition in good health for social assistance recipients.

In the early period, providers had the authority basically to prescribe specific supplements for their clients, up to a maximum of \$250 each monthly. In late 2006, this strategy for increasing the resources of recipients was complicated by regulatory change which required providers essentially to diagnose certain conditions for which specific allowances were assigned, again to a maximum of \$250 monthly.

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## BILL 152 (continued)

for some of the infrastructure investments to be devoted to upgrading social housing, for enhanced enforcement of labour standards, and for new programs targeted at obesity and literacy in high risk children.

As part of his response to the growing toll of the recession, the premier briefly floated the possibility in the week following the budget, that the government might renege on the last instalment of an earlier commitment to increase the provincial minimum wage to \$10.25 an hour by 2010. Thanks to the outrage of community and labour advocates, he quickly recanted. ♦

While the change might be practical where a provider was the primary care provider, it became much more difficult for Health Providers Against Poverty and others to conduct the community campaigns that had previously resulted in supplements for an estimated 10,000 recipients in 2005-06. With regret, Health Providers Against Poverty discontinued the campaign.

Early in 2009, we heard from a provider who opted to continue signing forms for the Special Diet, when he got word, through legal counsel at the Ontario Medical Association, that the Medical Director for the Ministry of Community and Social Services, Dr. DeMarchi, had raised concerns at the provider's practice. Following some investigative journalism by the Toronto Sun, they reported on March 5<sup>th</sup> that the City of Toronto Auditor General has agreed to follow-up on the alleged 'fraud'.

Reproduced below are some comments from the provider when we inquired about his February letter. For a copy of the 8 page letter responding to De Marchi's concerns and relayed through the OMA legal counsel, please contact the MRG office.

The circumstances of the interaction are given in my letter. I don't understand why he (Dr De Marchi) did not call me directly. Perhaps it was meant to frighten me since it was re-

layed through the Ontario Medical Association legal counsel Mr. Jim Simpson. I know Jim because he has negotiated on behalf of my physician group at the Occupational Health Clinic for Ontario Workers. We are a small group of physicians there and I managed to gain some experience at negotiation and writing briefs to the government using support from case laws. So far I have support from the Health Coalition and the "Stop-Community Food program."

There isn't much to do now until I hear back from the Ministry. They can either leave me alone or take the "actions" as outlined in my letter. Should they take action(s) against me then I will surely need your help (and a whole bunch of other folks!). Perhaps they want me to sweat it out. Luckily, I am not rattled one bit because of my thick skin! Folks are coming in from Hamilton and Waterloo in "bus" loads and it would be nice if they know of other health professionals who can help them in their cities. Of course, some help in Toronto is welcomed.

I realize the incredible stress the professionals had in completing the form and I understand completely if they decline to participate at this time. What I am doing is a stop gap measure. Raising the rate is the solution. Thanks again for your support. Please circulate my message to your group. ♦

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# MRG CALLS ON THE PREMIER TO HONOUR SPIRIT OF HIS POVERTY REDUCTION TARGETS

*Here is the text of a letter sent by Dr. Gordon Guyatt, March 16th, 2009 to the Premier, members of the Cabinet Committee on Poverty Reduction and provincial opposition leaders.*

I am writing on behalf of the Medical Reform Group to comment on your Poverty Reduction Strategy released in December of last year and urge you to commit to the \$100 nutrition supplement for every adult recipient of Ontario Works and the Ontario Disability Support Program. We observe with concern the current and worsening economic situation is quickly swelling the ranks of 'newly and nearly poor', which in turn, risks increasing mid-term voter disdain for non-responsive government initiatives.

Our members, physicians, residents and medical students who work predominantly in low income communities across Ontario, deal daily with clients who have great difficulty meeting Ontario Public Health standards for nutritious eating within the allocations currently provided. While our neighbours and colleagues in the 25 in 5 coalition were gratified by your government's action on its promise to begin the process of poverty reduction in Ontario, and to back the commitment up with legislated targets and timetables, many were disappointed at the patchwork of initiatives described as part of the strategy and the absence of a substantive financial commitment.

We remain very concerned that at a time when some private sector analysts are anticipating unemployment above 10 per cent by the end of this year, many more older adults will experience the hardships and health risks of being poor.

Our concerns can be grouped under 3 main headings:

## **1. A Comprehensive Financial Plan.**

The Ontario Poverty Reduction Strategy needs to outline a way to increase supports for those at the lower income levels. We think there are a number of ways to do this, not all of which require direct spending by your government, including

- ◆ improvements in Ontario employment standards and the minimum wage;
- ◆ strengthening Employment Insurance supports to accommodate the modern job realities of Ontarians so that more than 1 in 3 recently unemployed people qualify for this benefit;
- ◆ improvements and coordination in the provision of health and other social benefits so that those who are able to find employment need not reject or abandon it because of the cost of child care or drug coverage.

At the end of the day, as the local officers of public health are aware, there is a persistent inconsistency in the fact that public health units are mandated by existing legislation to report on the cost of a nutritious food basket, but have no resources to address the fact that at least in Toronto and most larger cities in Ontario, single adults have not been able to meet that legislated baseline for over 20 years. We continue to be concerned as well not only with the ability of municipalities to discharge their provincially-mandated social services responsibilities from the property tax base but also the commitment of the Province of Ontario regardless of federal support.

## **2. Eliminating Child Poverty**

It is unacceptable that half a million Ontario children live below the poverty line and the benefits of adequate nutrition and early learning and childcare for optimal growth and development are clear.

We think it is equally unacceptable that another half a million Ontarians over 50 live in poverty and not only have difficulty eating well without jeopardizing their housing, but according to the Ontario Health Quality Council, represent an increasing proportion of the population with preventable disease and who will put increasing pressure on our health care system over the next decade. We recognize that incremental increases in the Ontario and Canada Child Benefit have improved the life chances of children in poor families but you can do so much more simply by raising adult benefits now to accommodate at minimum the recommendations for healthy eating already mandated for public health units.

*(continued on page 12)*

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# MRG CALLS ON THE PREMIER TO HONOUR SPIRIT OF HIS POVERTY REDUCTION TARGETS (continued)

## 3. Smart Service Coordination

Smart service coordination can stretch limited resources further and avoid increasing the gaps between the poor and not quite poor. The service enhancements announced as part of the December Poverty Reduction Strategy (Parenting and Family Literacy Centres) need to complement and to be integrated and coordinated with previous generations of Best Start and the not insignificant resources of the public education and municipal recreation systems so that children and youth across Toronto and across Ontario can have affordable access.

An effective service enhancement approach would also take account of the woeful lack of on-going youth programming outside a few designated neighbourhoods; these programs need to be community-based and coordinated with existing resources in schools and other community organizations. Health advocates and providers more generally call on you to consider carefully the wisdom of a targeted anti-obesity program for children that does not appear to acknowledge either that overweight children very often have overweight parents, or to take advantage of the best current program thinking that would implement evidence-based health promotion programming.

We are fully aware that, to be effective, many of our suggestions will require more collaboration and coordination with other levels of government and with experienced and trusted community organizations. The Ontario government is in an enviable position of governing for the next 2 years with a majority, and so we call on you to use that majority to give leadership and hope to all Ontarians now. The health of our children and all of our communities needs to be a priority now.

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## FEDERAL BUDGET 2009

Janet Maber

After a time out at the recommendation of the Governor General, finance minister Jim Flaherty returned to the House of Commons in January 2009 with a recognition that as a member of the global community, Canada was not likely to emerge completely unscathed from the world recession. His Economic Action Plan of January 27<sup>th</sup> was designed, in the minister's words, to stimulate growth and ensure Canada's post-recession competitiveness.

Budget highlights included:

- ◆ Almost \$30 billion in support to the Canadian economy—1.9 per cent of GDP—and for close to 190,000 jobs
- ◆ Creation of Extraordinary Financing Framework with

up to \$200 billion in credit for business development, coupled with a single Canadian securities regulator

- ◆ Canadian Skills and Transition Strategy with \$8.3 billion in enhancements to Employment Insurance and skills development funds
- ◆ Personal Income Tax relief of \$20 billion in 2008-09 and the next 5 years
- ◆ Supports for housing including energy retrofits, social housing investment and tax measures to increase home ownership and assist owners to renovate, to a total of \$7.8 billion

- ◆ Federal investment in infrastructure in 'shovel-ready' transportation, energy, electronics and communications projects, representing almost \$12 billion over 2 years

- ◆ Up to \$7.5 billion in targeted support for auto, forestry and manufacturing as well as clean energy projects

The day following the budget, the Canadian Centre for Policy Alternatives, which had made a series of concrete recommendations in the Alternative Federal Budget, published a critique which identified the following issues:

- ◆ Almost a third of the \$30 billion stimulus package is con-

(continued on page 13)

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# EUROPE YES, PRIVATIZATION NO, SAY DOCTORS

The foregone conclusion of CMA President Robert Ouellet's tour of Europe has emerged: a call for European style reliance on for-profit delivery of health care.

"Dr. Ouellet's conclusions were made before he ever stepped on the plane," said MRG spokesperson Dr. Ahmed Bayoumi. "One could predict his conclusions from his conflict of interest: Dr. Ouellet is a longstanding private clinic owner and privatization advocate."

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## FEDERAL BUDGET 2009 (continued)

tingent on spending by provincial and local governments

- ◆ Focus on broad based tax cuts will have much less impact on job creation than direct infrastructure spending
- ◆ Essentially cosmetic amendments to Employment Insurance will not address fundamental unfairness of a system in which only about one third of those who contribute can claim in time of need.

The Canadian Centre for Policy Alternatives urged the Federal government to reconsider, and recommended that the provinces do what they could to redress the federal failings. ◆

To the extent that European systems have advantages over Canada's, Dr. Ouellet could have focused on a number of differences. Typically, European systems of care are 75% to 85% publicly funded, in contrast to Canada's 70%. Publicly funded systems are more efficient, with far lower overhead than privately funded systems.

Several European countries, including France and Germany, spend a larger proportion of their gross domestic product on health care than Canada does - 1% to 2% more, which represents a huge additional investment in health care.

Furthermore, European social systems are much stronger than Canada's with much more comprehensive unemployment insurance, more generous social assistance programs, public child care programs and parental benefits. The result is a smaller

gap between low and high incomes – a gap that, in Canada, feeds ill health and health care costs.

Meanwhile, direct comparisons between for-profit and not-for-profit delivery show higher death rates, and higher expense in for-profit hospitals, and higher death rates in for-profit dialysis facilities.

"Yes, we should be more like Europe," said another MRG spokesperson, Dr. Irfan Dhalla. "More publicly funded health care including drug costs, an appropriate investment in the training of doctors and nurses, and social support systems that effectively combat the poverty that is a major cause of ill health. What we don't need is more for-profit health care for the personal advantage of physicians like Dr. Ouellet." ◆

*Released by the Medical Reform Group February 8, 2009*

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# CATASTROPHIC DRUG COVERAGE IS NOT ENOUGH

Janet Maher

Members will be aware that we are part of the Canadian Health Coalition which is leading a federal lobby this spring on the national pharmacare strategy. This item summarizes some of the main arguments for lobbying against the currently favoured plan of ‘starting the ball rolling’ with a catastrophic drug coverage plan.

## **What is Catastrophic Drug Coverage?**

When former Saskatchewan premier Roy Romanow reported in 2002 on his inquiry on the future of health care in Canada, his recommendations included a start on national pharmacare, which would begin with what was termed catastrophic drug coverage for Canadians—a plan which would provide for public intervention when an individual’s drug costs exceeded a given threshold or proportion of income.

In essence, what he proposed was a national agency which would expand significantly the current health protection role of Health Canada, as well as to establish a national formulary to reduce inequities in access across the country, provide the basis for negotiating drug prices on a national basis, and see the federal government reimburse 50 per cent of drug expenditures from the formulary over an individual threshold of \$1,500 annually. The expectation was that as time went on, the reimbursement rate could be increased, or the threshold decreased, or both, as provincial governments agreed to participate, much as happened with physician and hospital services in the 1960s.

This proposal was one of several forwarded to the Ministers of Health, who met in the fall of 2003 to draw up a 10 year accord on health care, and was tabled as part of the 2004 National Pharmaceuticals Strategy.

As we saw in the January report of the Health Council of Canada, *The National Pharmaceuticals Strategy: A prescription unfulfilled*, although the early years of the strategy were marked by a collaborative approach, virtually nothing has happened since 2006. Thus, we still have neither a national formulary nor the prospect of one. While there have been discussions on improving access to drugs for rare conditions, we still have no agreement on either the threshold for individual contributions or provisions by reimbursement either federally, provincially or territorially.

## **The Canadian Health Coalition Plan**

Over the past year the Canadian Health Coalition has been reviewing the National Pharmaceuticals Strategy, and its shortcomings. In addition to the snail’s pace of discussions, the strategy as currently enunciated does nothing to address directly or control the escalating cost of drugs, which currently account for more than is spent in the public system on physicians, and only slightly less than is currently spent on hospitals.

The CHC proposal would provide for

- ◆ a universal public program to cover everyone for all drugs in the formulary, in the same way as

doctors and hospitals are currently covered

- ◆ program expenses would be cost-shared by federal and provincial governments, with employers contributing through the tax system
- ◆ a single public plan would minimize administrative costs
- ◆ a single public plan would reduce costs by facilitating bulk purchase and other strategies for controlling drug expenditures.

Along with Joel Lexchin who works with the coalition’s pharmacare working group on our behalf, several Steering Committee members have been working over the spring to organize lobby meetings with federal MPs in Southern Ontario on this issue. ◆

*For more on the coalition activities, see [www.healthcoalition.ca/LifeBeforePharmacare.html](http://www.healthcoalition.ca/LifeBeforePharmacare.html)*

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# NEW E-LIST LAUNCHED

The Steering Committee recently recommended we give members an opportunity to read and respond to news releases as we send them to our media list. We have subscribed all members for whom we have e-mail addresses to the list. This list will be limited to our

media releases, with a note to let us know as [medicalreform@sympatico.ca](mailto:medicalreform@sympatico.ca) if you do NOT want to receive the notices or if we do not have a current email address for you.

The new list is set up as [medical-reform-news](mailto:medical-reform-news@googlegroups.com) on the googlegroups list service. This means a member can

send an e-mail message to the whole list at [medical-reform-news@googlegroups.com](mailto:medical-reform-news@googlegroups.com). ♦

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## MRG MEMBERSHIP APPLICATION

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

### Membership Fees

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

Please specify membership category:

\_\_\_\_\_

Please specify areas of interest and expertise:

\_\_\_\_\_

\_\_\_\_\_

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

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

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

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

\_\_\_\_\_

Account holder's name (print)

\_\_\_\_\_

Account holder's signature

\_\_\_\_\_

Date

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# ONTARIO GOVERNMENT RELENTS A LITTLE ON OHIP FOR IMMIGRANTS AND REFUGEES

*Janet Maher*

Several Ontario members have been involved in the lobby of the Ontario Minister of Health and Long Term Care to eliminate the 90 day wait period for OHIP for immigrants and refugees.

As can be seen from this message from Dr. Meb Rashid at Access Alliance, who has been leading the lobby effort, there has finally been some movement at the Ministry of Health and Long Term Care, in that the waiting period has now been eliminated for convention refugees—but not yet for other categories of immigrants or permanent residents.

To all,

Below is the response that we have already obtained from the Minister's office. They seem to have already resolved this issue and have withdrawn their efforts to impose the 90 day wait. They

seemed genuinely consultative and heard the concerns that we have. I wanted to thank all of you that were involved in this effort and in particular Dr. Keystone who helped us access channels that were not available to us directly. He continues to give us much more support than the tropical medicine advice that he generously provides.

I also want to speak to the success of the Toronto Refugee Health Network in this process. It was through our coming together that we heard about the issue and were able to mobilize.

I believe that the time that the members have already put into this group has resulted in improved services for refugees—I think this effort is a good example. We had over 120 health care

providers sign on to the letter within 5 days! Fortunately it appears that letter will not have to be used. Nevertheless, it reminds me of the immense number of dedicated health care workers that are committed to providing excellent health care for those with the highest needs.

Interestingly, we had the opportunity to discuss the 90 day waiting period for permanent residents also and the Minister's representative seemed interested in the issue. We are forwarding information to them around this.

Perhaps there will be a possibility to address this issue in the future.

Thanks again for all the sincere effort that was put into ensuring that the refugees that we see have the best care possible. ♦

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

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