Medical Reform

Newsletter of the Medical Reform Group

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CONTENT WITHOUT CONTEXT: EDUCATION OF CANADIAN HEALTH PROFESSIONALS LACKS TEACHING ON CANADA'S HEALTH CARE SYSTEM

Member Ritika Goel reports on the analysis of a recent Students for Medicare survey of its members, health professional students across Ontario, on the quality of their education and training on the Canadian Health Care system. The survey was originally undertaken following the 2010 Students for Medicare conference where many delegates indicated their lack of familiarity and preparedness to engage in current public debates on health care in their own country.

Health Professional Education: Our Hypothesis

Students in health professional programs are expected to have knowledge and opinions on various aspects of the health care system.[1,2] However, it is unknown whether training programs adequately prepare students to assess and propose solutions to problems faced by Canada's health care system. In this regard, health policy teaching in health professional school curricula lags behind the dynamic public discussions that are taking place.[1,3,4] This raises concerns as to whether health professional programs' curricula are sufficiently providing students with knowledge to confidently navigate the challenges faced by the health care system and help effect change. As future health care providers, it is essential that health professional students be equipped with the necessary knowledge to actively participate in shaping the system to advocate for optimal care and population health outcomes.[1,2]

Background: A Survey

Students for Medicare, a group of students, health professionals and allies, disseminated a survey to health professional students across Ontario. The survey aimed to assess students' perceptions of the quantity and importance of education on a variety of topics relating to the Canadian health care system. Online surveys were distributed to health professional programs in Ontario and received an impressive 977 responses, of which 828 were completed surveys. Respondents included students in medicine, nursing, health policy, public health, social work, pharmacy, and midwifery from schools across Ontario. The survey assessed students' perceived level of formal education about the health care system, the mode of education, and their satisfaction with that education. It also explored whether students had sought out education outside their formal curricula and whether this was felt to be useful.

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Editorial committee this issue: 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

As we go to press, the prime minister and premiers are preparing to meet in Vancouver for what could turn out to be the opener in negotiations on the future of the 2004 Accord.

However, as our spring meeting speaker Armine Yalnizyan noted, there is unlikely to be much resolved at the federal-provincial meeting. Fully five of the ten provinces will have elections before the end of the year—and no one is taking bets that the current incumbents will be back at the helm. So rather than seeing any constructive movement on the future of Medicare, we can much more likely expect messaging from the current premiers focused more on the home voting audience. As many analysts have already pointed out, the field will likely be pretty clear for the Prime Minister to test some of his pet 'experimental' projects, and begin to unravel the value of a renewed accord by negotiating with provinces and territories one by one.

Ontario is one of the provinces slated for an election, on October 6th. Currently the pundits see the likely result as a return of the Tories, and if their preliminary campaign salvos and platform document, 'changebook', provide any indication, we can look forward to tax relief, a focus on patient-centred care and 'cleaning up' after nearly a decade of Liberals. MRG is discussing strategies for improving access, equity and accountability with our usual allies, Canadian Doctors for Medicare, the Registered Nurses Association of Ontario, Ontario Health Coalition and the Canadian Health Coalition and we expect our fall issue will outline some of the best resources in time for the fall election campaigns.

But there is much reason for optimism. This issue includes two contributions from Students for Medicare. The first reports on a cross-Canada survey they conducted on the state of their education as health professionals. Although most schools get high marks for specifically medical or nursing education, the survey points out that discussion of the broader issues around funding and health policy leave a lot to be desired. The second reports on an April 26th session Students for Medicare hosted with CMA president Jeffrey Turnbull on the perspectives of young health professionals on the future of medicare.

Also included in this issue is a report on the work of several of our members in briefing the Ontario Social Assistance Review Commission on what we might assume are obvious links between poverty and health. As reported by Gary Bloch who attended the late June briefing, their presentation was very well received by the commissioners. ♦

CONTENT WITHOUT CONTEXT (continued)

Demographics

Students reported school attended, field of study, expected date of graduation and their year of study. Schools represented:

- University of Toronto (42 per cent), McMaster University (11 per cent), York University (10 per cent)
- Other schools (33 per cent with the following in order of representation): University of Western Ontario, University of Ottawa, Humber College, Carleton University, Ryerson University, Queen's University, Northern Ontario School of Medicine, George Brown College, Mohawk College.

Health professional disciplines represented:

- Medicine (37 per cent), Nursing (27 per cent), Pharmacy (17 per cent)
- Other (22 per cent): Social work, physicians' assistants, midwifery, public health and other

Students were well represented across stages of training.

Comfort with Various Health Care Topics

Students rated their comfort level in their knowledge of the following health care topics:

- Single payer versus private funding
- For-profit versus not-for profit delivery
- The Canada Health Act
- Federal versus provincial versus municipal responsibilities
- Services funded or not funded in the provinces
- Medication coverage in the province
- Comparison of our system with other countries
- Identifying who was not able to access provincial health insurance

Of note:

- Only 9.4 per cent of respondents felt comfortable with their level of knowledge in every topic.
- 66 per cent of respondents were uncomfortable with their level of knowledge in at least one area.
- Only 11 per cent of students graduating soon (in 2010 or 2011) felt comfortable in all areas, whereas 59 per cent still felt uncomfortable in at least one area.
- Students stating they were comfortable in all areas were much more likely to state they learned these topics through research projects, reports, and small group sessions in their curriculum than those who were uncomfortable in at least one area.
- Students stating they were comfortable in all areas were much more likely to state they were engaged in community events, conferences, and informal discussions outside their curriculum than those who were uncomfortable in at least one area.

Importance of Various Health Care Topics for Future Career

Students rated how important they felt the above-mentioned health care topics are for their careers.

Highly rated as **very important**:

- Medication coverage in your province - 65 per cent rated this very important
- Services funded or not funded in your province - 62 per cent rated this very important

Less likely to be rated as very important:

- Comparison of our system to other countries - only 31 per cent rated this very important
- Single payer vs. private funding - only 37 per cent rated this very important

This may indicate students are interested in practical knowledge teaching them what they have to know in practice about coverage and services in their own province while the other issues may seem abstract. We are concerned with the lack of importance placed on an issue such as single payer vs. private funding which is likely the single most talked about issue in the public sphere. This response may reflect a lack of discussion of these important issues in school.

Formal Education on Various Health Care Topics

- When asked what different ways students learn about the health care system in their formal curriculum, 20 per cent of students reported having **no formal teaching on these issues**.
- 70 per cent of students stated that "**Current issues in health care**" should be better covered in their formal curriculum.
- **Didactic lectures** (65 per cent - is this of ALL respondents or of those who responded as having some teaching) and **assigned readings** (65 per cent) were the **most common methods** by which students reported having learned about these issues in their formal curricula. The least common were reports, projects and research, but those who learned in this fashion were more likely to rate that they felt comfortable in all the health care areas we listed.

Extra-Curricular Learning on Health Care Topics

- 75 per cent of students reported engaging in independent reading, media
- 58 per cent of students reported

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engaging in informal discussions
- 32 per cent of students reported attending community events, conferences etc.
- 15 per cent of students reported engaging in an optional elective
- Approximately 10 per cent reported engaging in NO extracurricular learning on these issues

A Knowledge-Based Question

We asked students whether Canada's health care system is generally one of private or public financing, and private or public delivery. (We were looking for the **most** correct answer.)

- **Only 52 per cent answered the question correctly: public funding, private delivery**
- Second most popular, at 45 per cent was public funding, public delivery
- 3rd or 4th year students were slightly more likely to provide the correct answer

Suggestions for Improvement Provided by Students

Given the ability to leave free text comments, students gave numerous suggestions as to how their curricula could be improved including some common themes:

- Less interest in lectures or textbooks
- More interest in **interactive discussions around current events**
- **Mandatory inclusion** of teaching on Medicare and health care systems
- Better access to **public resources, extracurricular activities** (conferences, workshops, debates).
- More opportunities for **advocacy** or public discussion
- Better utilization of **new media** through websites, online lectures

Conclusion and Future Directions

There were several important themes elicited by this survey.

- Many students in health professional programs across Ontario identify a lack of comfort with their knowledge of the health care system.
- Students feel they are not receiving adequate education on issues pertaining to the health care system and would like this to be included in their formal curricula.
- Students report seeking out external sources of information to gain knowledge about these important issues, and those who did so, ranked their comfort level higher.
- Further incorporation of health care issues in curricula could be achieved through discussions, workshops, online lectures and learning modules, among other less-traditional teaching means.
- Students report being very interested in the topic "Current issues in health care" which may identify a gap in formal education and also a desire to better understand the conversations being had on health care in Canada outside classrooms.

Students for Medicare believes health professional training programs should re-evaluate their curricula on Canada's health care system to better educate students on the issues they deem important. Without knowledge of current issues and the structure of Canada's health care system, students are unable to form informed opinions on the system they will be working within and issues in the public conversation on health care. Without this knowledge, students may be discouraged from shaping health policy in the future.4,6 Further, knowledge of the health care system is outlined as an objective in many health professional school curricula such as is outlined by the Medical Council of Canada for medical schools.5 We will continue to advocate for further inclusion of these issues in formal curricula and also support students' choices to seek out this information through informal means, while hoping to see change at the curriculum level in our health professional schools based on these findings.

ABOUT STUDENTS FOR MEDICARE

Students for Medicare is a grassroots organization of students and practitioners of nursing, midwifery, medicine, public policy, other disciplines, and allies. We advocate for maintaining and strengthening a publicly-funded, not-for-profit health care system.

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STUDENTS FOR MEDICARE HOSTS CMA STUDENT TOWNHALL

As part of his commitment to engage health care professionals in shaping the CMA response to the public debate on Medicare, President Turnbull sought opportunities to discuss his transformation agenda with various sectors of the CMA membership, and he responded warmly to an invitation from the Student for Medicare to host a meeting with students in the Greater Toronto Area. Member Ritika Goel reports on the April 26, 2011 meeting of Students for Medicare in Toronto with CMA President, Jeffrey Turnbull and Canadian Doctors for Medicare Chair, Danielle Martin.

We asked students from various health professions in small groups to answer three questions put forth by the CMA as part of their health care transformation discussion, as well as a final general question on health care. Here's what they said!

Q1. The law underpinning our system- the Canada Health Act- dates back to the 1980's. It covers only doctor and hospital care. Do you think it should be broadened to include things like pharmacare and long term care?

Key Themes:

The concept of "medically necessary" being only physician and hospital services was strongly challenged in the discussion. An expansion of the Canada Health Act was greatly supported, with support for inclusion of services such as long term care, pharmacare, nurse practitioners billing as independent providers, vision care, physiotherapy and occupational therapy. Pharmacare was mentioned on multiple occasions, including mention of a decreased cost with such a system due to better negotiation with pharmaceutical companies, better ability to manage chronic disease as well as a way to decrease variability between provinces in terms of coverage.

Q2. It is important for citizens to feel they are receiving good value for their health care. What would you consider good value?

Key Themes:

Students defined good value in health care as a more equitable system that allows all individuals the availability of appropriate care in a timely and accessible manner. They talked about access as defined by location, time and affordability but also as minimizing barriers by providing care that is non-judgemental, client-centred and sensitive for people of various cultures, those of the LGBTQ community, those with mental health issues and those without immigration status. This would require a system that looked at all aspects of an individual, not just their biological selves. Recommendations were also made for health care practitioners to strive for more interprofessional collaboration, good communication both between disciplines and their clients as well as maintain a single payer system to keep down costs. A focus on primary care and prevention rather than costly acute care as well as providing professionals the ability to work to their full scope was seen as obtaining good value. Other recommendations included decreasing variability of physicians' incomes across specialties, decreasing hospital CEO salaries, avoiding unnecessary tests to appease clients and ensuring providers have a healthy workplace so as to provide good care. Along the same vein, good value was seen as care where providers can engage in a caring relationship without rushing patients.

Q3. Patients and their families play an important part in their health care. What do you think Canadians' responsibilities are, now and in the future, with regard to their health?

Key Themes:

Students unanimously interpreted this question as the collective responsibility of Canadians as a whole to govern what is taking place within the health care system. They suggested advocacy for poverty reduction, better urban planning, infrastructure building, health education and promotion, access to good food, access to clean water and more. Students also felt Canadians should be educating themselves on issues of the health care debate in Canada and be engaged within their communities and government on these issues.

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CONTENT WITHOUT CONTEXT (continued)

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SPRING MEMBERS' MEETING: ARMINE YALNIZYAN ON FEDERAL FUNDING ISSUES

Janet Maher

The spring members' meeting, which took place in Toronto on June15th, 2011, featured Armine Yalnizyan, Senior Economist at the Canadian Centre for Policy Alternatives. Her focus was to educate members on federal provincial funding issues as they relate to health care and to lead a discussion on strategies for the next period.

Yalnizyan began by noting that in the recent federal election, health care remained the number one issue for Canadians. However, none of the parties talked about it until midway through the election campaign. And their interventions when they came were curiously unsatisfying—with references to increasing or expanding funding by 6 per cent a year, with virtually no discussion on what the money was going to go for, whether it was going to be conditional, or what might be cut in return.

If we begin by noting that the current budget for the Canada Health Transfer is $27 billion for 2011. By the end of the accord in 2013, that means we can anticipate $30 billion dollars. But beyond that, the picture is a little more murky. In particular for Harper, it is not clear whether he has in mind growing the cash transfer or the tax transfer by 6 per cent or some combination of the two. While other parties recommended a range of performance conditions, the discussion as of May 2nd is not at all clear.

And according to Yalnizyan, it won't get clear anytime in the near future. The fall of 2011 will see 7 provincial and territorial elections, with the likelihood that although health care may remain top of mind, not much direct negotiating will happen until at least early 2012. She sees this as a good time to come together with like minded people to try and set the agenda on what the 6 per cent can and should mean.

A few of her observations on health care spending that we might want to keep in mind as we plan. Without a doubt, spending on health care has grown faster over the past decade than any other area of social spending in the country and the most consistent buzz is about how sustainable medicare is going to be because of an aging population.

As Yalnizyan sees it, the government has two major choices to make around funding: they can spend more money and/or they can manage the money they spend in new more effective ways. Realistically, in the last report on the accord, the best we did was to tie some funding to certain expectations, like the amount of diagnostic technology there would be. There have been great strides made in reducing wait times, but that is not the only issue.

As Yalnizyan reminds us, another item in the 2004 accord was a proposal to increase access to primary care -- which some jurisdictions have done and others have not. There was also an expectation that electronic health records would be further along than they are and that there would be some movement at minimum on access to catastrophic drug coverage. Neither of these latter has happened. So, in the end, she notes, we've increased the money for health care, but not kept very good track of all of the elements that were agreed to by the provinces. So, going forward, it would seem to make sense to have some process to keep track of what people (read provinces and the federal government)

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STUDENTS FOR MEDICARE (continued)

Q4. What principles do we value in our health care system and how can we improve our system to espouse those values?

Key Themes:

Students stated various principles that they valued in the health care system including justice, equity, equality, fairness, comprehensiveness, consistency, compassion, and systematic communication between health care providers. Students wanted a system with accessibility to health care for all, regardless of immigration status and wanted an examination of the root causes of issues, looking at health in a holistic manner rather than just health care. Some specific concerns included the expansion of private clinics that claim to have private delivery, but have been charging for medically necessary services - students felt the federal government should be living up to its role by holding the provinces accountable for such contravention of the Canada Health Act. Students were also concerned about the upcoming Canada Health Accord negotiation in 2014 and felt it important to consider which party will best represent the interests of Canadians in such talks.♦

are agreeing to and what and when they are actually delivering. And it is increasingly clear that that kind of accountability cannot just be left to government. If we are serious about accountability, we need to make sure that our governments are being accountable for the money -- at a provincial and federal level.

The Election Platforms of the Leading Parties

The Conservatives eliminated much of the debate at the starting gate by committing in their platform to a 6 per cent increase as far as 2015-16, which is approximately when we can expect another federal election. According to Yalnizyan, at this point, Harper is not looking for an accord or a renewal of the existing accord. And so far no federal-provincial-territorial meetings have been discussed. The very minimal discussion that has so far occurred has focused on identifying jurisdictions that are willing to "experiment".

In 2003, Ralph Klein got into a lot of trouble, when he talked about a third way, where the province of Alberta would actually opt out of cash transfers, take tax points instead, and effectively opt out of the Canada Health Act. In principle, that is not so different from what Quebec has been proposing, and in some cases, doing basically the 1960s—an on-going wrangle for the province of Quebec to have control over its taxation power. So, as Yalnizyan sees it, there will be at minimum two jurisdictions that are looking more tax room than cash so that they are not obliged to use the Canada Health Act. She notes that although PM Harper has talked about maintaining the Canada Health Act, that talk is nuanced with a sixth principle.

Yalnizyan points to the recent discussions on improvements to the Canada Pension Plan as offering a model for what may happen. In that case, all the provinces except for Alberta and Quebec had long been on side until April, 2011 to improve the Canada pension plan, by increasing both contributions and the benefit level and expanding to cover more people. At the last moment in April, Alberta reneged on the consensus and so pension reform which looked promising, and the costs of which would basically be borne by residents and employers, and not by government, is now off the table.

Yalnizayn cautions that we need also to remember that the current prime minister campaigned before he got into federal politics on the need to firewall Alberta, as well as on the need to get federal government constrained deeply and to get Ottawa out of everyone's life.

Now in charge of the federal government, he has said repeatedly that he wants to return the federal government to 1867 values, and a British North America Act which takes the federal government out of all social programs. In this scheme, if you have a problem with social programs, it will be clear, as noted by columnist Andrew Coyne during the election that you need talk to your province.

What does provincial experimentation mean? It does not mean stopping public funding, with which the Conservatives have no problem. However, the current limitation of the Canada Health Act to not for profit service is a problem for them.

As Yalnizyan points out, wait time, the persistent hot-button issue, is about insufficient supply of services. The reason why there are shorter wait times in other jurisdictions is because there's more unused capacity in the system. It can run more quickly. The argument of the privatizers is that we can create a second tier where people can pay for some services. They posit that that will speed up care for those who pay for it. What is less an issue with them is what happens to those who don't or can't pay. Assuming as we must that there's only a given supply, there is a limit on how much care (in the first or second tier) can be provided unless there is an increase in the supply of providers. Really, people are just going to go from one place to another. Some of them for some period of time will double dip in both tiers of the system, some providers will do a certain number of hours in the public system and a certain number of hours in the private system but at some point they're going to get burned out, so the number of providers overall really does count. Thus, Yalnizyan argues, because there's been no commitment to increasing the supply of health care, you know the commitment to faster wait time and public funding simply means more private service is on the menu.

Public-Private Partnerships (P3s)

One of the features of the last couple of budgets is a $1.8 billion dollar P3 fund. The Harper government has indicated that they are committed to making that thing work, including requiring every big federally funded project be vetted with the so-called P3 lens. Essentially they turn to the private sector for financing construction, design, operation maintenance, or some combination of that. According to Yalnizyan, usually it's the financing part of it that is what bankrupts the system and holds us hostage to it.

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So the P3 system is there to provide the money. As with the infrastructure funds, there is room to stimulate the economy, but generally only on the condition that our municipal and provincial partners carry more of the weight than they have typically in the past. In fact, if you take a look at how much of the cost was carried by the federal government – in this recession the proportion borne by the federal government, is about half, or a little less than half of what it was going into the latest recession.

According to Yalnizyan, in previous recessions the federal share was around 70 per cent in the 1990s and about 85 per cent in the 1980s. So they really sanitized themselves from the cost of this recession, largely because they insisted that 'lower' levels of government equal their contribution. And the P3 is another way of doing that, with other levels of government providing funding as well as getting private sector partners to provide the cash to move forward.

As she notes, government financing levels at the lowest they've ever been in our economic history, the prime lending rate for governments is below the rate it was at in 1933 when the Bank of Canada was established.

So, we should be borrowing now and reducing cost for taxpayers for generations to come. And that's an important area we can be working.

We have never seen these levels of borrowing. This is the cheapest time for the federal government and borrowing's all about economy to scale. So P3 goes absolutely against that, it actually raises the cost of borrowing, stick it to the taxpayer for the next 15-20-30 years depending on the length of the project, is absolutely nuts.

Pharmacare and Sustainability

When it comes to sustainability, Yalnizyan defers to her colleague Bob Evans, and his arguments for national pharmacare. As she related, he speaks of two major drivers of health care costs. One is the cost of drugs and pharamceuticals, and the second is physician billing.

What is the physician billing part of that? As Yalnizyan notes, everybody who feels an ache or pain wants the doctor to do something about it. And what doctors do, they either prescribe something or send the patient for diagnostic services to find out what is wrong.

So it's either drugs or diagnostics. Those are the items that are really going through the roof right now. But, there are things we can do to control, maintain, and manage those costs. One of those things is to put/keep more in a government's purview in terms of the purchasing of drugs. Another point is to handle the escalation of diagnostic costs similarly. At a minimum, there could be more bulk procurement of equipment.

Other solutions are more linked to changing the health care culture. In particular as the technology gets more advanced, there is the possibility of almost instantaneous knowledge and increased expectations about how to respond to a diagnosis. A further issue and there seems no end of curiosity about what could go wrong. Yalnizyan notes there is rarely a discussion of the value and costs of so-called designer drugs, linked to a patient's DNA profile. She does not counsel avoiding those benefits of technology, but points out that the cost and effectiveness of such care should be the subject of discussion, particularly in the context of debates about sustainability

There is a whole Pizza Pizza delivery promise approach is actually trumping what we understand about wait times. If anything, notes Yalnizyan, the lessons we have learned in the last 100 years in Canada is that giving more timely access to primary care for everyone reduces all sorts of problems down the road—it really is what your grandmother taught you, a stitch in time saves nine. So if you get timely access to primary care, you don't need to worry as much about the other things, but when we serve, we're used to getting our resources in the health care system towards more acute care, particular surgery, particular interventions, you're taking resources away from other things.

An important and comprehensive report by Marc Andre Gagnon shows how Canada could save up to $11 billion dollars on drugs by introducing four different mechanisms [see MEDICAL REFORM Issue 153]. The biggest of those is called bulk purchasing and the Ontario government has already really taken a lead on it. If all jurisdictions did something similar, and we had a common purchasing plan, even a common formulary at a national level of the most used drugs and we were bulk purchasing at that level could be saving a lot more money. It seems unlikely to happen with the current federal government but it could happen with a coalition of provinces that are saying we can't afford this to go on.

This is another place where some concentrated lobbying needs to happen to avoid increasing rather than decreasing drug costs for Canadians. Yalnizyan reminds the mem-

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bers that the federal government is currently negotiating the CETA, the Canada-Europe Trade Agreement, where the main interest of Europe is a further extension on drug patent rights. A conservative estimate by some McMaster health economists is that the CETA could cost Canadians an additional $2.8 billion worth of European drugs (based on current procurement patterns. So the federal government has a choice, either raise costs by $2.8 billion or lower them by $11 billion. As she notes, e have to make clear that there are really clear choices available to contain costs.

Electronic Health Records

A further item begging for progress is the use of electronic health records. As Yalnizyan points out, Michael Kirby in 2002 wrote very famously that health care is the biggest cottage industry in Canadian history. Patient charts are still mostly little notes that nobody can read. Although we are moving forwards on the e-health front but we are still pitifully behind and it'll probably take another 10 years to get there, where electronic transmission of information can reduce complications, minimize errors and reduce bottlenecks in service delivery -- and improve the access to certain things that are already out there as well as reducing wait times that way too.

Accountability for Current Spending

Yalnizyan speaks of her final bugaboo as the way doctors and hospitals get paid. Hospitals themselves are being pushed in the direction that the UK National Health Service, pushed the hospitals to take block funds which would be based on services or units of service delivered. As well, the NHS gave physicians a certain amount of money to deal with their patients. These experiments have been carefully watched by Canadian health policy analysts, and Yalnizyan is sure this is one of the areas for the Harper government's so-called experiments—actually all sorts of boutique ways of dealing with getting physician services to patients. Debate around this has been going on basically since the 1960s when the doctors went on strike about how they were going to be paid in Saskatchewan.

Under the Canada Health Act, there is a provision for monitoring spending on public and private delivery and withholding funds for provinces who contravene the Act. However, since its implementation in 1984, less than $5 million has been withheld. Lawyer Stephen Shrybman actually wrote a paper in 2003 showing how for years the Canada Health Act has not enforced the very rule that it asked for which is an annual report.

An increasing issue since that time has been the availability of information—and the ending of the long form census is only one example of the difficulties advocates will have in the years to come. Yalnizyan counsels a careful tracking of the spending of the money, particularly that linked with the so-called Health Accords. A related question is to get a clear answer on the accountability for the recently guaranteed 6 per cent increase. For example, it would make sense to allocate at least part of the 6 per cent increase to deal with the persistent health shortages problem.

What can Doctors Do?

Yalnizyan admits there is insufficient evidence to determine whether the current supply of doctors is sufficient or not. But she thinks doctors themselves are well placed to work with other health providers to figure out what the best way is to get doctors to do what they and only they do really well and to let nurses and other health people take care of more routine work within their own scope of practice. There are ways of making much better use of our primary care service providers and any number of researchers in the Medical Reform Group can teach us all lessons about that.

And there are a million ways of facilitating a lot of this change without significant additional expense. For example, she notes the potential of Employment Insurance to provide leaves for people, including all kinds of health providers, to upgrade their skills, maintain their practice and provide excellent care. Certainly in the third world, when CIDA assists in health care reforms elsewhere, they look quite explicitly to who can be trained in the basic stuff, because there's a very limited number of nurses and doctors and they've got to do their job properly. If we can do this in the so-called third world, observes Yalnizyan, it surely can be done here.

Another issue Yalnizyan anticipates is an increase in user fees and she thinks special vigilance is critical in Ontario, particularly if we see a change in the governing party in October. She reminded members that in his last provincial budget, Quebec Premier Charest was intent on introducing a $25 per visit user fee. That got pushed back at the very last minute, but it really required doctors to say why it would not work. Yalnizyan noted, "It's nice when people like me say it but it's way more effective for doctors to talk about it. And also to talk about where that money

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SPRING MEMBERS' MEETING (continued)

can be coming from." She notes that those who have experience with P3s need to share their experience of the waste in P3s, actually having the first person singular voice talking about how money is being wasted in the name of trying to offload some of these costs in the short term.

One final point, in her view, is to talk about how tax cuts fit in. without a doubt, the income class who have most benefited from the tax cuts experience in the last ten years are the middle-aged middle to upper income groups. To imagine the impact, she notes that in 2006, at the federal level alone, $223 billion either were implemented or promised over the 5 year period to 2011. For comparison, she reminded members about a recent Obama speech in Denver where he decried the US giving away $2.5 trillion over 10 years—if scaled to Canada, we have had almost twice the level of tax cuts than the US. So it will be important to have people starting to talk out against this. And again there is a US example, where Yalnizyan observes on affinity groups like Millionaires For Taxes starting up.

She also recommends calling the prime minister when he talks about fitness as a primary determinate of our health status. She anticipates he's going to have an awful lot of people sitting with him, looking at their kids who are playing game boy and video games and whatnot and not getting out and doing stuff, so the proposed tax breaks for fitness and cultural activities will have an automatic resonance for a lot of people. Physicians are among the best qualified to help deflate that balloon and broaden the social determinants of health story to what we know is the biggest driver of ill health –and that is the growing income inequality.

It's the biggest driver of ill health both for the poor but for all of society, it changes the gradient of health outcome, it's bad public policy, we can do something about it, there's a very manageable something we can do. So broaden the whole look at what we mean by social determinants of health but also take into account the next generation.

Moreover, there still is the pharma story. It's always very evocative when doctors can talk about pragmatic things that can be done to manage costs and deliver good quality health care. And every time we save money in some place, it can be piled right back into the system to improve health outcomes elsewhere. When doctors say it, it means something different than when the politicians say it.

For more information on the work of the Canadian Centre for Policy Alternatives, go to www.policyalternatives.ca. ♦

FALSE POSITIVE: PRIVATE PROFIT IN CANADA'S MEDICAL LABORATORIES

Kingston member Adam Newman reviews a new book by a long time colleague, nurse Ross Sutherland. Sutherland is a co-chair of the Ontario Health Coalition.

This timely and insightful look at one dark corner of our health care system has some important lessons for those of us Canadians who consider this to be a cherished and defining national institution. Informed by his many years of community and hospital nursing and drawing on research he undertook for his Master's degree in political economy, Ross Sutherland's work has a unique and valuable perspective. While he musters an impressive body of research and an appreciation for the political and economic context of health policy, he never loses touch with their significance for the realities of those who are working in and dependent on the health care system. In the interests of full disclosure, I belong to the former category, working as I do as one of Sutherland's colleagues in a community health centre in downtown Kingston.

The real value of Sutherland's work comes from the light it sheds on how ideology, money and professional jurisdiction combine and conspire to distort the workings of a system which most of us believe to be fundamental to our wellbeing and, further, to be run in the public interest. In fact, although we are all told that Canada's health care system is unique in its emphasis on universality and public payment, much of the actual services that comprise this sector are delivered by private professional entrepreneurs using a corporate model.

It is important to keep in mind that our current single-payer system was born in an era when physicians occupied a central and powerful position in society at large and in the health care system specifically. This meant that while governments across the country -- starting in 1946 in Saskatchewan and culminating in the federal Medical Care Act in 1966 -- agreed to pay for services for all citizens, the actual delivery of those

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FALSE POSITIVE (continued)

services – where, how much, what kind – was left up to a powerful group of elite professionals who often had conflicting interests. Sutherland documents how not only did doctors reserve the right to decide which tests and with what frequency they might order them, they also frequently owned and operated the commercial laboratories that were paid by the government to carry out these tests. Wealthy physicians have always had close ties to the political elites that form most provincial and federal governments and share their ideological conviction that privately run enterprises were preferable to, if not more efficient than, public institutions. Not surprisingly, in addition to drawing our attention to the "unholy alliance between the medical profession and for-profit laboratories" (page 99), Sutherland exposes some of the links between these same corporations and the government bodies that affect laboratory policy. All of this explains why the system persists despite the fact that it favours the poor performance and inefficiency of for-profit labs over publicly run facilities.

Sutherland's clinical career has been spent in Ontario, and it was there that he first became interested in the contradictions and failures inherent in the private delivery of public services – the result of which was a thesis on the political economy of Ontario's community labs for which he was awarded a Master of Arts by the Institute of Political Economy at Carlton University. While he draws on this research to illustrate the histories of the three main commercial laboratories operating in Ontario – Gamma Dynacare, Canadian Medical Laboratories and MDS – he spends considerable time surveying the landscape in the other nine provinces as well, aptly showing that there is nothing universal about the way health care is structured and delivered in Canada, at least in the community laboratory sector. Along the way, he demonstrates some of the ways in which for-profit corporations have influenced the political process to their advantage through donations, lobbying, and the inevitable overlap between board members and directors of some of these companies and all three of the political parties that have held power in Ontario.

Despite the inconsistencies, contradictions and waste that Sutherland so meticulously documents, his most impressive accomplishment is to leave us with reason to hope: he notes that, in our publicly managed hospital laboratories, all provinces currently possess the means to provide high quality, accessible services more reliably and to more communities than are presently served by for-profit enterprises; Sutherland marshals impressive arguments for those among us who are working to realize something better.♦

POVERTY, HEALTH AND SOCIAL ASSISTANCE: SUBMISSION TO THE COMMISSION FOR THE REVIEW OF SOCIAL ASSISTANCE IN ONTARIO

As reported in MEDICAL REFORM 152, in late 2010 the Ontario government appointed a commission consisting of the former chief of Statistics Canada, Dr. Munir Sheikh and past president of the United Way of Toronto Frances Lankin to review income security and social assistance in the province with a view to providing practical, relevant and conrete recommendations to improve social assistance and simplify income security to facilitate employment and expand opportunities for those available to work while ensuring equity and dignity for all. The commissioners have been proactive in seeking input and will continue to do so until September 1st.

They met with a group of health providers in Toronto on June 21st, 2011. This brief, which summarizes their key messages was well received.

Key messages:

- Poverty is a key determinant of health. Those subsisting on social assistance live in significant poverty, particularly single persons without children on Ontario Works.
- An appropriate benefit structure would be based on the concept of health as a resource for everyday living. Health is a prerequisite for employment and participation in society and should be a shared outcome of the entire system.
- An inadequate social assistance system can lead to increased health care costs. Resources for welfare should be framed as in-

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vestments towards a sustainable health care system.

The relationship between poverty and poor health

The Public Health Agency of Canada has stated that poverty is the leading social determinant of health.[1] Social determinants are the structures of society that have been found to promote or constrain health at the individual and population level. Living in poverty negatively impacts other determinants, leading to food insecurity, inadequate housing, a lack of social supports and reduced access to health services.[2]

Social assistance recipients live in poverty, particularly single persons without children on Ontario Works. Not surprisingly, an analysis of 2005 Canadian Community Health Survey data found social assistance recipients in Ontario to be consistently sicker than the working poor and the non-poor.[3]

- Income appears to influence health outcomes on a **gradient**, meaning it impacts not only those at the very bottom, but for those at middle-income levels as well.[4]
- A Statistics Canada study concluded that income-related causes of mortality account for **24 per cent of potential years of life lost**, second only to 30 per cent for cancer.[5]
- For **cardiovascular disease**, the prevalence amongst those with the lowest incomes is 17 per cent higher than average.[6] If everyone had the mortality rates of the highest income category, there would be 21 per cent fewer premature deaths each year due to cardiovascular disease in Toronto.[7]
- **Diabetes** is more than twice as prevalent in the lowest income groups in Ontario, and diabetes-related mortality rates are 70 per cent higher in women, and 58 per cent higher among men.[8]
- The prevalence of **hypertension, arthritis, COPD and asthma** is higher amongst lower income individuals, as is the risk of suffering from multiple chronic conditions.[9,10]
- **Cancer** prevalence rates amongst the poor have been shown to be higher for lung, oral, and cervical cancers[11.12.13] while a U.S. study demonstrated lower 5-year survival rates for most cancers.
- There is a consistent relationship between low socio-economic status and the prevalence of **mental illness**.[15] For example, depression rates in the lowest income quintile are 58 per cent higher than the Canadian average.[16] The suicide attempt rate among social assistance recipients is 18 times higher than among higher income individuals.[17]
- **Growing up in poverty** has been associated with increased adult morbidity and mortality from a wide range of conditions.[18] A change in socio-economic status later in life does not fully reduce the difference.[19]

Responses to the Commission's Discussion Paper: Issues and Ideas (June 2011)

Issue 1: Reasonable expectations and necessary supports to employment

- As cited in the Discussion Paper, "many people with health problems can work and indeed want to work in ways compatible with their health condition, so any policy based on the assumption that they cannot work is fundamentally flawed."[20]
- Employers should be given incentives to provide job opportunities for those on social assistance that wish to work, with the understanding that this can be positive for people's health.
- Addressing the health needs of people on assistance is crucial to their employability. Adequate resources to achieve good physical and mental health are required and must precede efforts to encourage employment.
- The barriers to, and solutions for, addressing these needs should be assessed in collaboration with people living on assistance. Key solutions may include flexible work hours, working from home, facilitating attendance at health care-related appointments, the long-term continuation of drug benefit plans and transportation allowances.
- Increased access to rehabilitation services, particularly those no longer covered by OHIP, should be negotiated with the MOHLTC.

Issue 2: Appropriate Benefit Structure

- As noted in the Discussion paper, "in some benefit classes, overall benefit levels of social assistance are not adequate".
- Benefits should be determined from the perspective of maintaining health as a resource for everyday living, including transitioning to employment.
- A short-term social assistance system should provide a level of income that allows for at minimum a basic healthy lifestyle – including access to a nutritious diet and adequate housing. The Nu-

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tritious Food Basket, published by each local public health unit in Ontario, provides a starting point. From a health perspective, this level is the bare minimum required to avoid doing harm.

- A long-term disability benefits system should extend this logic to ensure a level of income that allows people to maintain their health over the long-term. No absolute income threshold exists over which the health benefits of a higher income diminish.
- Assistance rates based on maintaining and promoting health and minimizing the impact of disability could be established and monitored by an independent body, resting on the legitimacy of keeping our most vulnerable citizens healthy.
- A holistic recovery model, as developed within the field of mental health, is essential, based on principles such as individualized and person-centred, empowerment, strengths-based, responsibility and respect.

Issue 3: Making the system easier to understand

- The current system has many barriers to obtaining assistance, given that the rules appear to be based on the myth that there is a large amount of fraud in the system.
- As illustrated by the "Zero Dollar Linda" case study, where a woman on ODSP was financially penalized for working, people are often trapped by the more than 800 rules and regulations of the system, despite a desire to better their situation.[21]
- Key solutions include making the system more transparent, easier to navigate and the government should provide independent advisors to assist recipients.[22]
- Health and social service providers should be educated and encouraged to ensure their most vulnerable clients are able to access all supports to which they are entitled. Forms and applications should be simplified and easy to complete.
- Maintaining the dignity of recipients should be the foundation of the social assistance system, particularly with regards to disclosing personal health information.

Issue 4: System viability over the long term

- As noted in the Commission's discussion paper, there is a lack of "a shared understanding of the expected outcomes of Ontario's social assistance system".
- A key outcome should be health maintenance and improvement. This objective will address the sustainability of both the health and social assistance systems by maximizing employability and minimizing long-term health care costs.[23]
- A Federal/Provincial/Territorial Health Disparities Task Group estimated that health disparities, many due to economic disparities, increased the cost of health care in Canada by 20 per cent or approximately $35 billion.[24]
- System integration should begin with collaboration between the MCSS and the MOHLTC. Key additional data should include the impact of improved assistance rates on health care utilization and costs, and make use of the current ability to link datasets.[25]

Issue 5: An integrated Ontario position on income security

- The provincial government is constitutionally responsible for health and social services.
- If gaps exist in federal programs (e.g. Employment Insurance), citizens should be covered by provincial programs. A failure to do so results in increased costs to other provincial programs, including health care, education and corrections.
- We recommend taking a whole-of-government approach to developing a comprehensive social security program.
- Working with all sectors of society, particularly people living on social assistance, the provincial government should advocate for a renewed federal health accord that is grounded in the social determinants of health.

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JUST RELEASED: EVERYTHING YOU EVER WANTED TO KNOW ABOUT HEALTH CARE AND TAXES

In collaboration with its partners, the Ontario Health Coalition has just released a 4-page election broadsheet summarizing basic facts and figures around health spending in Ontario and Canada. You can download the leaflet from their website at www.ontariohealthcoalition.ca or check with your local coalition representatives.♦

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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.

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USER FEES AND EXTRA BILLING

Janet Maher

Like the Canadian Doctors for Medicare, MRG members were pleased to see Ontario Health Minister Deb Matthews take leadership on stopping illegal user fees being charged in private clinics, and think this is an important issue for all provinces who have been inclined to turn a blind eye to practices which leave patients vulnerable when they can least resist. The specific issue was reinforced by a recent gastroenterology study which reported on the extent of fees charged for medically necessary services. The government has committed to set up a hot-line to take reports on extra-billing, and bears monitoring.

That small but important victory reminded one of our members of some of the MRG's recent discussions with the College of Physicians and Surgeons of Ontario over the use and abuse of block fees for services not included in the OHIP Schedule of Benefits. Specifically, in the new primary care payment and incentive models, there seem to be continuing reports of family doctors charging additional fees for phone calls, emails, and other services. This appears to contradict at minimum the spirit of the new payment incentives integrated in 2005-06 primary care reforms.

Similarly, some patients in public meetings have recently reported on what seems to be an increasing incidence of requests to pay up front for lab tests not covered under the Schedule of Benefits. Since most make the assumption that physicians or other providers only recommend medically necessary tests, they ask if there is a way to know and assess in advance whether they should either pay or submit to the tests.

The MRG Steering Committee is preparing for a meeting with College and Ministry representatives we met with in 2007, and would be interested in any feedback on this issue as we do so. Please contact us as soon as possible at medicalreform@sympatico.ca or (416) 787-5246. ♦

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