Medical Reform

Newsletter of the Medical Reform Group

Issue 157 Volume 31, Number 4 Spring 2012

DRUG SHORTAGE

In late February, we began to hear increasingly urgent media reports of hospital procedures being delayed or canceled as a result of drug shortages. Member Joel Lexchin traveled to Ottawa on April 2nd, 2012 to advise the Federal Standing Committee on Health, with the following message.

There has been a lot of wringing of hands and gnashing of teeth lately over the issue of drug shortages. And rightly so. Many of the drugs that are in short supply are essential for delivering the health care that people need. But media pundits and politicians are throwing up their hands and wondering how we got to this position. Did drug shortages drop out of the sky unexpectedly? The fire at the Sandoz plant in Quebec is the immediate cause for the situation we find ourselves in, but the shortage in drugs has been building for years now.

If you want to understand why there are drug shortages then the answer, as it usually is, is to follow the money. In this case the money means that the drugs that are in short supply are almost uniformly low margin products and nearly all of them are generics. You can make a good profit out of manufacturing and selling generics, just look at Apotex as one example with Canadian sales in 2010 of $1.35 billion. But because the profit margins on generics are low companies may lose interest in them and move their money into some more profitable product. Moreover, unless the drug happens to be a big seller often only one or two generic companies are interested in making it. (Sandoz is the generic arm of the Swiss multinational Novartis.)

Money is also the reason that the production of the active ingredients, the part of the pill that does the work, has been steadily moving to places like China and India. Production costs there are much lower than they are in Canada and the United States and that translates into a higher profit margin for the drug companies. However, as recent scandals like melamine in milk or contaminated heparin show, there are problems in relying so heavily on countries where quality control is sometimes very iffy and where corruption may mean unreliable inspection procedures.

All it took to turn a simmering problem into a raging fire

(continued on page 3)

INSIDE

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

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 to purchase multiple copies of individual newsletters or of annual subscriptions at reduced rates can be made.

Articles and letters on health-related issues are welcomed. Submissions should be typed, or sent by e-mail to medicalreform@sympatico.ca.

Send correspondence to:
MEDICAL REFORM
Box 40074, RPO Marlee
Toronto, Ontario M6B 4K4.
Telephone: (416) 787-5246
Fax: (416) 352-1454
E-mail: medicalreform@sympatico.ca

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

Editorial committee this issue: Ritika Goel, Gordon Guyatt, 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 noted in the winter issue of MEDICAL REFORM, the parties in the provincial legislature are continuing to jockey for space, with scant regard for the public they are collectively elected to serve.

On March 27th, Ontario Finance Minister Dwight Duncan tabled the 2012 provincial budget (described elsewhere in this issue). Many had expected the budget to follow closely the advice of former federal finance bureaucrat and TD chief economist Don Drummond who had reported on a year-long assessment of the role of public services in Ontario. After noting that full-day kindergarten, one of McGuinty's legacy programs would not be changed or delayed as Drummond recommended, much of the rest of the budget direction did follow the austerity theme. No new taxes were proposed, although a couple of those promised in the 2011 budget were actually rescinded. However, what galled many activists was the apparent equanimity with which the government also proposed that the most vulnerable 'share the pain' by freezing social assistance rates for another year, and delaying part of the projected increase in the Ontario Child Benefit for another year.

What has complicated the scene somewhat is the refusal of the government, being in a minority government situation, to strike committees, including the Standing Committee on Finance and Economic Affairs which normally holds pre-budget hearings across the province toward the end of the New Year recess. Had they done so, they might have heard some of the rumblings which resulted in the launch of the Doctors for Fair Taxation (and other similar) campaigns—where some of the higher income earners explicitly called for a review of the tax cut agenda which has characterized both federal and provincial budgets for most of the last decade.

As we go to press, the provincial conservative leader has announced that he will vote against the budget as it does not move far enough in the direction of deficit reduction for his members. NDP leader Andrea Horwath has announced after receiving record feedback from her supporters, that she will have some conditions for supporting the budget—namely some new revenue, in the form of an additional tax bracket for earners above $500,000, and some additional protection for the vulnerable. To their credit, we understand the premier and finance minister are seriously negotiating in an effort to avoid a second election within the year. ♦

was…a fire. Health Canada has been blithely ignoring this issue for years. There has not been any planning about how to deal with a full-scale crisis like the one that we now find ourselves facing. Health Minister Leona Aglukkaq claims that Health Canada has acted proactively on the grounds that her department has previously approved applications from other generic manufacturers who are able to make the drugs that are now in short supply. (Although these applications have been approved the companies in question have never marketed their products, emphasizing the point that there is not much money to be made from them.)

But she is just trying to deflect attention from the inactivity in her department. Passively approving applications to make drugs but doing nothing to ensure that those drugs are actually available is not planning. Up until now the drug companies, both brand and generic, have done little to deal with supply questions beyond a voluntary pledge to collect information about shortages and pending shortages and post this information on a web site.

What would real planning look like? Here are my recommendations.

1. Health Canada should convene an expert committee to identify off-patent drugs that are supplied by only one company and that are considered "critical" to medical care. Examples of critical products might be things such as chemotherapeutic agents, morphine, anesthetic agents and drugs to treat epilepsy.

2. Once these critical drugs have been identified Health Canada should then pro-actively identify possible alternative sources of these products and determine whether the companies making these products are prepared to supply Canada in the event of an emergency. Contingency contracts could then be negotiated with interested suppliers.

3. Any company marketing one of these critical drugs in Canada should be required to give Health Canada a minimum of 2 years notice before they stop supplying the products. Health Canada should maintain a list of these drugs and post this list publicly.

4. In the future, one of the conditions for granting a Notice of Compliance to sell one of these critical drugs in Canada should be a commitment by the company to guarantee the availability of the drug for a minimum of 3 years.

These measures will help to ensure a continuous supply of drugs for Canadians. However, they do not necessarily guarantee that these drugs will be available at a reasonable price in the event of an emergency.

Manufacturers may try and take advantage of such a situation by charging a premium for their products. At that point, a desperate government would have little choice. Therefore, I propose that the federal government should establish a publicly owned generic drug company to manufacture some of these drugs that are deemed critical to medical care. Recall that up until the mid 1980s Connaught Labs was a publicly owned vaccine and insulin manufacturer.

Drug shortages are not going to vanish and may become a fact of life. Doing nothing, which seems to be the federal government's preferred choice, is not an option.

Joel Lexchin works in an emergency department in Toronto where he tries not to prescribe drugs that are in short supply. ♦

Reprinted from the Pharmawatch blog, maintained by Colleen Fuller and Janet Currie; it can be accessed at http://pharmawatchcanada.wordpress.com/

HARPER'S FEDERAL BUDGET AND THE ALTERNATIVE FEDERAL BUDGET

The 2012 Federal Budget, released March 29th, hits all the bases at least nominally, in the sense that the Harper government has acknowledged many of the most intractable problems for our country—the need for innovation, better outcomes in the labour force, especially for younger and older workers, sustainable resource and social development. Many of the solutions, however, are likely to leave most of us disappointed.

Recognition of the need to support innovation is met with a promise of $500 million, primarily to fund new a private sector research and development venture capital fund and to 'refocus' the National Research Council on the commercialization of Canadian innovation for the marketplace.

The focus on better outcomes in the labour force consists of a range of incentives for youth, including aboriginal youth, to train via placements and internships. Addressing the concerns of employers, the budget statement offers more flexible immigration with putative improvements in the Temporary Foreign Worker Program and the Foreign Credentials Recognition Program—in an effort to demonstrate that the Harper Government "priority is clearly on meeting labour force demands."

At the same time, reductions of nearly 20,000 full-time public servants over the next 3 years reduce the number of relative high income jobs. The cuts are likely to adversely affect many of the inspection programs including health and environmental protection and transportation safety, potentially jeopordizing safety in the areas being cut. In spite of recent Auditor General concerns expressed about the regulatory regimes relating to food, hazardous materials and transportation safety, the Department of National Defence has already announced a reduction of 1,100 in civilian employees and Health Canada expects to reduce its workforce by a little over 10%.

The March 29th budget did reconfirm the government's commitment to honour an election commitment of 6 per cent annual health transfers to the provinces and territories to the end of 2015-16. Thereafter, transfers would be linked to the rate of growth in Gross Domestic Product, with a floor of 3 per cent annually. In spite of a considerable lobby in the fall of 2011, this commitment comes with no strings attached—leaving the provinces and territories to spend those funds without regard, for example to the provisions of the Canada Health Act, ignoring federal and provincial government reports which have recommended linking this spending to outcomes.

Well before the budget was actually released, the government had signaled internationally its intention to weaken supports for seniors as part of a new direction for sustainability of social programs. As part of a strategy to reduce government liability for old age security, the federal government expects to phase in an increase in the age of eligibility for Old Age Security and Guaranteed Income Supplement from 65 to 67 years, beginning in 2023, and attempt to change the rate of government contribution to defined benefit pensions from approximately 80% in the case of MPs and non-unionized public servants and approximately 50% in the case of unionized public servants to closer to 20%, the rate they note is in effect for most private sector pensions. Meanwhile, supports for retirement income for middle income earners will begin as soon as legislation can be prepared with tax incentives for delaying the collection of government pensions and new tax incentives to encourage pooled RRSPs.

A further element of the 2012 budget, anticipated since the election of the current government last May is the result of a program review which anticipates the reduction of $75 billion in federal program spending by almost 7% over the next three years.

Announcements of the specific impacts of this review are expected over the next couple of months, but in some of the early announcements, we understand that the $275 million in new investments for aboriginal education and training will be balanced by a $250 million reduction in general program funding.

The Alternative Federal Budget 2012, assembled by the Canadian Centre for Policy Alternatives on the basis of discussions with a broad range of voluntary sector stakeholders, and published a few weeks in advance of the Federal Budget takes a very different approach, beginning with a discussion of revenue options. They note that even without any new tax cuts in 2012, revenues under the current regime will exceed planned expenditures by 2014-15—meaning that subsequent surpluses could be dedicated to the debt that preoccupies the government.

(continued on page 5)

FEDERAL BUDGET (continued)

Nonetheless, the Alternative Budget proposes two 'new' tax measures that could address a range of infrastructure needs. Those measures are a single additional tax bracket for individual incomes over $250,000 at 35%, which would raise $3.5 billion in fiscal 2012-13. A rollback of federal corporate cuts to the 2010 level and revision of individual tax subsidies (hospitality, capital gains, and stock options allowances) would raise something in excess of $10 billion annually in 2013-14.

The Alternative Federal Budget 2012 also describes a comprehensive approach to climate change including a carbon tax that would raise $17 billion in 2014-15, balances in a series of refunds for low- and medium-income tax payers and productivity linked incentives for green jobs.

As in past years, the Alternative Budget working group continues to press for substantial infrastructure investment, in part to address what they see as the increasing deterioration of roads, bridges, water and sanitary services. The alternative budget proposes dedicating approximately 1.5% of HST/GST receipts to a REBUILD CANADA fund for improving municipal infrastructure.

The Alternative Federal Budget also proposes a significant leadership role for the federal government in health care. They would earmark the one-third of the federal increase in transfers to the provinces to transformational initiatives, projects and programs specifically linked to better health status outcomes. In addition, they describe a plan for the partial implementation of a National Pharmacare strategy with approximately $11.5 billion over 3 years. ♦

For more information: See the Federal Budget, Jobs Growth and Long-term Prosperity; Economic Action Plan 2012 at www.budget.gc.ca/2012/plan/pdf/Plan2012-eng.pdf and CCPA, A Budget for the Rest of Us, Alternative Federal Budget 2012 athttp://www.policyalternatives.ca/afb2012.

A WELCOME VOICE FROM DOCTORS, SAYS THE MEDICAL REFORM GROUP

A group of doctors who rank among Canada's top income earners launched a campaign March 22, 2012 to urge governments to raise taxes on the rich rather than eliminate necessary public services in the so-called age of austerity. They have called for a series of additional tax brackets in the Ontario income tax regime for net incomes above $100,000 so that the highest income earners would pay an average of 2% more than currently. This, they estimate would raise and additional $3.5 billion in federal taxes and $1.7 billion for Ontario coffers. ♦

For more information, see www.doctorsforfairtaxation.ca

We are pleased to hear from a new campaign, Doctors for Fair Taxation," said Dr. Gordon Guyatt today. "As we noted in our pre-budget brief to the Ontario Government a few weeks ago, Ontarians are increasingly coming to view a fiscal model using tax reduction as its only strategy as short-sighted. In our experience, where value for money can be demonstrated, we believe most tax payers would prefer to pay to maintain and enhance systems which support access and equity for all the residents in our province, and our country."

Guyatt continued, "The proportion of tax we pay on income has been going down over the past decade, as successive governments rush to the lowest common denominator. The $2.5 billion in personal income tax revenue we collected in Ontario in 2009 but not in 2010 would have made a significant difference, for example, in the speed of implementation of the provincial poverty reduction strategy, or full day kindergarten, or in providing additional home care—all important items on the wish list of us all. As a doctors' organization, we fully support a fairer and more progressivetaxation structure."

The Medical Reform Group is encouraging its members to support the call of Doctors for Fair Taxation, and look forward to working with them in the coming months. ♦

Released by the Medical Reform Group, March 23, 2012

LET'S AGREE ON THE DIAGNOSIS BEFORE PRESCRIPTION, SAY DOCTORS

The Drummond commission may offer suggestions that will improve our ability to better meet the needs of Ontarians for health, education and other public services and where it can be demonstrated that new ways of doing things will improve access, then we should make every effort to see that they are implemented as quickly and fairly as possible, said Dr. Gordon Guyatt of the Medical Reform Group today.

Former TD Bank chief economist was appointed by the premier last June following the 2011provincial budget to lead a commission and make recommendations for the 2012 budget on the Future of Public Services in Ontario. Speculation on the recommendations of the Drummond Commission, expect to report this week, is reaching a fever pitch, and many citizens are rightly alarmed about threats to public services without any direct discussion of the diagnosis..

"A balanced approach would set out needs and the optimal resources to meet them, along with options that address the gap between the two. So far the debate has been completely lopsided, focusing on reducing services to meet an arbitrary resource ceiling, without assessing whether ways should be found to address the service gaps, explained Ritika Goel, another MRG member. "That is the yardstick by which we will be measuring the report when it is released," she added.♦

Released by the Medical Reform Group, February 15, 2012

DOCTORS' GROUP SUPPORTS FREEZE ON DOCTORS' INCOMES

One of the items in Dalton McGuinty's austerity budget calls for a freeze on doctors' incomes. The Medical Reform Group, a doctors' organization that advocates for high quality universal health care in Canada, today expressed strong support for this budget item.

"Doctors are by far the best paid professionals in the medical system, and among the highest income earners in Canada" said MRG spokesperson Gordon Guyatt. "At a time when much lower paid public sector workers are being asked to forego anticipated raises, it's only fair that governments hold the line on doctors' incomes."

During a decade filled with concerns about health care costs, doctors' incomes in Ontario have risen substantially. "Home care, pharmacare, and increasing capacity to cut wait times are all better expenditures than further increases to doctors' incomes" said another MRG spokesperson, Ahmed Bayoumi.

The MRG also applauds the budget for rolling back anticipated corporate tax cuts. What the government has failed to do, however, is institute needed tax increases to high income Ontarians - including doctors - to appropriately deal with the deficit.

"The MRG supports the message from Doctors for Fair Taxation," said Dr. Guyatt. "The government is making a mistake focusing exclusively on spending cuts as a way of dealing with the deficit. Canada is witnessing a growing disparity between rich and poor. A fairer and more progressive taxation structure would be one way to deal with that disparity while cutting the deficit, and it's an option that the Premier has regrettably ignored."♦

Released by the Medical Reform Group, March 29, 2012

PROVINCIAL BUDGET—STRONG ACTION FOR WHOM?

Janet Maher

Ontario's 2012 budget, delivered by the Finance Minister on March 27th, promises strong action for Ontario, and like the federal budget tabled in Ottawa two days later, starts from a premise that no new taxes can be levied.

Like the federal budget, public servants and public services are clearly in the crosshairs of the Mcguinty government. Among the highlights:

- Balancing the budget by 2017-18,
- Implementing savings of $4.9 billion over three years
- Delaying the general Corporate Income Tax rate and Business Education Tax rate reductions until the budget is balanced
- Capping the Ontario Clean Energy Benefit at 3,000 kWh per month
- Changing the Ontario Drug Benefit program so that about five per cent of seniors -- those with the highest incomes -- pay a larger share of their prescription drug costs
- Ensuring Ontario user fees recover more of the cost of providing programs and services
- Extending the pay freeze for MPPs for another two years -- for a total of five years
- Extending the pay freeze for executives at hospitals, universities, colleges, school boards and agencies for another two years.

What is not mentioned in the highlights are decisions that directly affect the most vulnerable. The budget reduces a previously announced increase in the Children's Benefit from $1,110 to $1,310 - the new benefit will be $1,210 annually. The budget also retains the basic social assistance allowance at $599 a month for single applicants.

The Action Plan for health care has three main elements:

- Reducing the growth in health care spending to an average of 2.1% annually over the next three years,
- Enhancing community based care to treat patients in alternative care settings such as non-profit clinics and at home, instead of in hospital
- Moving to activity-base funding models rather than global budgets.

Proposals include increasing investments in home care and community services by an average of four per cent annually for the next three years or $526 million per year by 2014–15. A new Seniors Strategy will expand house calls, increase access to home care. No specifics are yet available on the size of proposed investments in chronic care services provided in the community to ease pressure on long-term care homes' waiting lists and help reduce the number of patients in hospitals waiting for long-term care beds. The budget also anticipates increasing overall long term care home funding by 2.8 per cent in 2012–13, including a one per cent increase in direct care costs for long-term care home residents.

Ontario, in contrast to the federal government, has a minority of one, however, and the budget vote might provoke another election. The Conservatives have already announced that they will vote against the budget, as doing too little too slowly to 'rein in' spending. At press time, the NDP, who had campaigned during the election and afterwards on increasing revenue has proposed a new tax bracket for those who earn more than $500,000 as part of its requirements not to vote against the budget. Given the response in the last couple of weeks to proposals like those of Doctors for Fair Taxation and Lawyers for Fair Taxation, as well as ongoing advocacy by the social sector, the Liberals have begun to engage the NDP in discussions on the possibilities of gaining their support and avoiding a new election.♦

PRE-BUDGET BRIEF TO ONTARIO FINANCE AND ECONOMIC AFFAIRS COMMITTEE

This year, despite the minority government situation in Ontario the Standing Committee on Finance and Economic Affairs was not convened to hear pre-budget consultations. On the advice of the committee clerk, the Medical Reform Group submitted the following brief on March 16th, 2012, about 10 days before the budget was ultimately tabled.

This year, some considerable media attention has been paid in the first months of 2012 to the recent release of the government's Report of the Commission on the Reform of Ontario's Public Service, under the leadership of former TD Bank and Federal Finance Department economist, Don Drummond. Although we support recommendations which have the potential to eliminate waste and duplication, we are very concerned as health care providers that a lack of due diligence in designing and implementing reforms can exacerbate existing inequities and gaps in access; moreover, the government and other economic data we have had access to does not support either the alarmism of the Drummond Commission or the arbitrary exclusion of all options, both on the spending and revenue side of the budget. Our presentation will focus primarily on some of the main themes of the Drummond recommendations.

The Medical Reform Group and our main issues

The Medical Reform Group is a voluntary association of physicians and medical students which has advocated for over 30 years to improve the health of Ontarians and Canadians by monitoring the provision of public health care, and promoting equity and social justice. Over the years, we have advocated for maintaining and enhancing public infrastructure on a not for profit basis, addressing the high costs of drugs by lobbying for a national pharmacare program, and more effective use of multi-disciplinary teams in primary care and of enhanced home care as a smart solution to acute bed shortages. We welcome this opportunity to explain our concerns and recommendations about the 2012 Provincial Budget to the Standing Committee on Finance and Economic Affairs.

Background

The Commission on the Reform of Ontario's Public Service (Drummond Commission) was appointed in early 2011 with a limited mandate to review options for the reconfiguration of Ontario programs and services to meet the target of eliminating the provincial deficit by 2017-18, without considering any increased revenue and to report with its findings in advance of the 2012 budget. Further, although the commissioners took it upon themselves to consult with a range of government departments and agencies, this commission, in contrast to most previous commissions, was not encouraged to seek or facilitate democratic input.

Since 2008, in the wake of a much more critical economic situation in the US and Europe, Ontario has been at the brink of recession, as manufacturing and services struggle to cope with poorer growth prospects and the weakening of our industrial sector. Although technically out of the recession, jobs numbers in Ontario have not recovered, and so fewer residents are in the position of being able to care well for themselves and families. Although some capital infusions from the federal government have addressed critical infrastructure needs, this has been spotty at best, and there has been little renewal in areas such as water, transportation and housing, which could both provide jobs and improve operations and or facilitate more effective program delivery in a number of areas.

We acknowledge Ontarians have been able to enjoy an increased level of care over the years, as treatments have become available that earlier generations could only hope for. This has increased expectations for all of us, and Ontarians and Canadians deserve an opportunity to debate the value of spending on such innovations.

The Health Sector

One of the biggest issues driving waitlists and which has

(continued on page 9)

PRE-BUDGET BRIEF TO ONTARIO FINANCE AND ECONOMIC AFFAIRS COMMITTEE (continued)

rarely been directly addressed either in the Drummond Report or elsewhere is the closure of beds and layoffs of nursing and other allied health professionals, health providers whose role is central to the speedy clearance of beds.

The hospital restructuring exercise of the late 1990s reduced Ontario's acute care coverage to among the lowest in the country; however, the investments in non-hospital care—home care and long term care—which facilitated that reduction, have been inconsistent and insufficient, resulting in persistent bottlenecks. The shift to regional health authorities has done little to address those bottlenecks beyond highlight the pressures on women and families to bridge the gap with voluntary caregiving and advocacy for loved ones.

Drummond Recommendations Regarding Health: A Mixed Bag

The Medical Reform Group has long advocated for universal first-dollar coverage of prescription drugs, and we believe this best serves the long term interests of all Canadian. Thus, Drummond's conclusion that cheaper drug programs are needed and his support for bulk buying initiatives and moves to national drug insurance are to be lauded. However, the same chapter of the report recommends reducing costs to government of drugs for social assistance recipients and seniors—a move which causes us grave concern.

While we acknowledge there is the possibility of improvements in the formulary, and implementation of a reference-based pricing structure could reduce costs, increasing the copayments already assessed to the most vulnerable, or limitations of the drugs on the formulary can have some serious adverse effects not only on such recipients, but also on the delivery system which relies on drug therapies to keep acute care occupancy rates low.

Other Drummond recommendations which revisit the scope of practice of all health professionals—physician assistants, extended class nurses, midwives, pharmacists, remind us of the abundance of excellent planning and policy proposals already available since 1990. It is not clear how quickly organizational culture change can be achieved—and to be fair, the present government has worked closely with stakeholders to facilitate smarter multi-disciplinary care.

Drummond acknowledges that less than 25 per cent of health status can be attributed to health care per se, with the remainder being attributed to determinants such as income and environment. Moreover, he acknowledges that the draconian cuts of social assistance by the Harris government, and the failure of social assistance rates to keep up with increases in the cost of living mean that the most vulnerable are in fact less well-off than in 1990. Nonetheless while he proposed limiting increases in health expenditures to 2.5% a year, his proposal is to keep social assistance increases to 0.5% overall.

While the report acknowledges the importance of expanding long term care and home care, Drummond's recommendations to limit increased access to long-term care make no sense. In a similar vein, while the report is long on suggestions for expenditure reductions, it seems to ignore that in certain areas, further investment, for example in E-Health, may be critical to 'working smarter." Further, although not specifically in the commission mandate, there is little guidance offered on the accountability needed on current and proposed spending, not only in E-Health and ORNGE, which happen to be current media issues.

Our proposals

Recommendation 1. We encourage the standing committee to take cautiously the alarmism of the Drummond Commission Report. As others have noted, the report is selective about cost comparisons even when using the government's own finance ministry data. We believe it is important to recognize that the proportion of the provincial budget dedicated to health care is a product not only of the insistence of Ontar-

(continued on page 10)

PRE-BUDGET BRIEF TO ONTARIO FINANCE AND ECONOMIC AFFAIRS COMMITTEE (continued)

ians on high quality health care for all, but of a political discourse and program of action which has systematically reduced revenues to support public services in general.

Recommendation 2. We believe the outsourcing of advice and services to private consultants at all levels of government means that there is a greater onus of accountability on government to ensure that current program priorities are met and/or that Ontarians clearly understand the consequences of program cuts. This means that residents must have an opportunity to have input to the government plans, such as is normally available in committee hearings.

Recommendation 3. As in past years, we acknowledge that the best contribution to health status is not necessarily health care, but a job that can provide the income for residents, and this should be a priority in the 2012 budget.

Recommendation 4. Ontario tax reform over the past 20 years has approximately halved the budget available to provide public services to our residents; Ontario is now one of the lowest tax areas on the continent, but there have been considerable costs—we think this is contributing both to the persistence of the recession and to increasing deterioration of infrastructure, including not only health facilities but public assets like water, sewage and transportation systems.

Recommendation 5. Many Ontarians are willing to pay more, and would prefer to do this in a way that improves life for all of us—this budget can and should include measures to increase the revenues available to do so. In addition to rescinding the planned personal income tax surtax the McGuinty government has already agreed to, there should be a parallel revocation of the planned corporate tax cut from 11.5 to 10% of corporate income.

Recommendation 6. The time has come for a comprehensive pharmacare program. Drummond has recommended beginning this with a commitment to bulk purchase of some of the most common drugs. A longer term strategy which parallels the national pharmacare strategy proposed by the Canadian Health Coalition could provide better coverage at less cost to Ontarians and with no more government expenditure than Ontario currently commits.

In conclusion, we believe that Ontarians are increasingly viewing the debate focused on tax reduction as short-sighted. Moreover, where value for money can be demonstrated, we believe most taxpayers would prefer to pay to maintain and enhance systems which have served us well in the past. If the Ontario taxpayers who pay personal income tax were to pay just 2 per cent more, or an average of about $20 per year per taxpayer, that would add half a billion to the $24billion of tax revenues of 2011.♦

LETTER TO PROVINCIAL LEADERS ON BUDGET

On April 2nd, Opposition Leader Hudak announced he would not support the 2012 Ontario Budget as presented. On April 3rd, member Ritika Goel wrote each of the provincial leaders to follow up on our brief (see previous item in this issue). Later the same day, NDP leader Andrea Horwath announced she had received over 5,000 letters on the budget and that she was beginning negotiations with the Liberals on NDP conditions for support of the 2012 Budget.

Dear Premier:

I am writing on behalf of the Medical Reform Group to follow up on the brief we had prepared earlier in March in anticipation of a meeting of the Standing Committee on Finance and Economic Affairs, regarding the budgetary choices facing Ontario residents. At that time we urged a healthy skepticism of an approach which focused only on spending cuts to answer the current imbalance between revenue and expenditures in the provincial budget.

Now a scant week after Minister Duncan presented his proposal, we continue to be concerned. As many, including our members, recommended, we were pleased that the rollbacks in income tax scheduled for this year were rescinded. However, we think there would be value in reconsidering the resource pie—not only in the 'smarter' allocation of current resources, but also in seeking additional revenues for programs and services which are valued by Ontarians.

While the essential flat-lining health budget and salaries of many of the province's professional public servants (including physicians and other health providers paid from the public purse) was also a good sign, we believe that the government could do a great deal more to shape change in this sector. Part of that shaping would be in much more precise allocation of resources to address directly some of the most notorious bottlenecks in the system. For example, while the focus of federal funding while it lasted was on eliminating waitlists in some designated areas, little was accomplished in a more permanent sense in addressing the base issues—of being able to discharge acute care patients to home or other community facilities because of the lack of such facilities and resources.

This situation has not changed since your government took over from the Conservatives in 2003; it leaves many families under pressure at time of crisis, and creates an environment where some would argue there needs to be event more private sector involvement to eliminate the bottlenecks. Our view is that health care is not like any other commodity—there is and should be no room for profit in this sector. Moreover, where such for profit activity already exists, government must play a role in regulating minimum service standards.

We have two very serious disappointments in the 2012 budget. One relates to your government's reluctance to address the issue of resources by adding to them, by increasing rather than seeking to decrease taxes and other revenues for programs and services that have demonstrated their effectiveness—like full-day kindergarten and high quality day care, for example. In the past several months we have heard suggestions from many well-paid professionals who value the programs and services that have made Ontario a good place to live—to the extent of urging a review of the tax regime to make it fairer and more progressive.

The other major disappointment, in view of the plenty in which those well-paid professionals live, is the halving of the scheduled increase in the child tax benefit and the freezing of social assistance rates at 2011 rates—even though with the cuts of the mid-1990s, they represent a decline in buying power to just over half of what the most vulnerable had to manage with a generation ago.

Our members can help in two important ways, and we look forward to the opportunity to discuss how needed improvements can begin to be made this year with regard to:

1. Better resource allocation within the health care system can improve programs and services for all; and
2. The evidence base for addressing the social determinants of health, including income, housing and social supports for all Ontarians.

I look forward to an opportunity to share some of our deliberations with you and your cabinet colleagues. ♦

Sincerely
Ritika Goel, MD for
The Medical Reform Group

BUDGET MEASURES JEOPARDIZE THE HEALTH OF ONTARIO'S POOR, SAYS PHYSICIAN GROUP

The new McGuinty budget reneges on a previous commitment to increase social assistance rates Ontario government's decision to freeze social assistance rates threatens the health of the most vulnerable of Ontario citizens, according to the Medical Reform Group.

"Poverty is one of the strongest predictors of poor health, associated with higher rates of heart disease, diabetes, and many other preventable diseases," said MRG spokesperson, Dr. Andrew Pinto. "Social assistance rates are already unconscionably low due to previous cuts and compromise the health of patients we see on a daily basis. Freezing rates effectively means cutting them – and as a consequence, undermines the health of our province's most vulnerable."

Not only is Dalton McGuinty's government cutting social assistance, but it is also delaying a planned $100 increase to the Ontario Child Benefit. "A child's well-being depends on a family's ability to pay for necessities. Continuing to force families to choose between nutritious meals, clean clothes, and stable housing means continuing to perpetuate the poverty cycle. It also puts children at unnecessary risk of long-term health problems," said Dr. Ritika Goel, another MRG spokesperson.

Freezing social assistance only saves a fraction of 1% of the total budget, but will cost substantially more in the medium-to-long run.

"These budget measures are remarkably shortsighted. They may lead to significant healthcare costs in the future," said Dr. Pinto. "If we ensured Ontario's poor a humane standard of living, we could anticipate substantially reducing suffering and may even saving money in the long term. That is why we have written to the premier and opposition leaders, urging them to reconsider and add fairness to their prescription for all Ontarians."

The Medical Reform Group is a voluntary association of physicians committed to ensuring access to high quality health care for all Canadians. ♦

Released by the Medical Reform Group, April 4, 2012

SOCIAL ASSISTANCE REVIEW—COMMISSION RUNNING OUT OF STEAM?

Janet Maher

After nearly 18 months on the job, the Ontario Commission for the Review is finally in the home stretch. Appointed in November 2010 as part of the McGuinty government's poverty reduction effort, the commission released a first discussion paper in June 2011, and engaged in a consultation June to August of 2011, receiving some 700 submissions from groups and individuals across the province. In February, 2012, they released a further Options Paper seeking feedback in the subsequent 6 weeks. The assessment of the Medical Reform Group was that the Options Paper was written with little regard for what the commissioners heard. A review of the Options Paper by the Income Security Advocacy Centre (ISAC) gives a summary of why we should not be holding our breath for a better deal for the most vulnerable.

1. No overriding vision to the Options, despite input on objectives to reduce poverty, treat people with dignity and transform a patchwork of inconsistent programs and initiatives into a system of income security and supports for recipients.

2. The Options Paper focuses on the Ontario Disability Support Program (ODSP), essentially ignoring Ontario Works (OW), the 'temporary' social assistance program, but with recommendations that would undermine the existing income security of ODSP recipients, with the po-

(continued on page 13)

SOCIAL ASSISTANCE REVIEW (continued)

tential elimination of some allowances and benefits. This comes despite clear evidence that the purchasing power of the monthly benefits has been halved since 1995 with the Harris cuts and the failure of subsequent budgets to reflect inflation.

Detailed options suggest one program for 'severely disabled' who could receive income through the tax system. ISAC is concerned at the lack of a definition for severely disabled in the current political and economic context of deficit reduction. The recommendations to remove benefits (health and assistive devices, housing and the like) out of social assistance and deliver them not just to current recipients but to all low income Ontarians, makes sense on the face of it. In the current economic and political context, the action on this may not necessarily happen concurrently with the change in benefits. Similarly, the Options Paper devotes considerable space to alternative delivery options for employment and training. Although it is difficult to disagree with many of the proposed innovations, delinking employment reforms from the income security package may also result in undermining current provisions as the current economic and political context' can become an excuse for delaying implementation of the innovative programs.

A further issue which is the subject of some discussion in the Options paper is a shift in program administration from verification as part of the application process to verification only in the case of audit, with sufficient penalties for non-compliance to deter applicants from abuse and fraud.

The final report of the Commission was set to follow the 2012 budget, in June of this year. We will be monitoring the results in the final report. ♦

LEGAL ACTION AGAINST THE CATALAN GOVERNMENT BY THE COALITION OF CITIZENS AFFECTED BY HEALTH CARE CUTS

Carles Muntaner, a social epidemiologist physician and professor of nursing, public health and psychiatry at the University of Toronto interested in social class and work-related social inequalities in health, reports on efforts of the Spanish OCCUPY movement in Catalonia to use the courts to enforce rights of access to health care. Catalonia has long been one of the strongholds of public free health care in Spain.

In Spain, access to health care is a right enjoyed by all citizens under both the Spanish Constitution and the Catalan Constitution, guaranteed and protected by the laws of both. However, public health care in the Spanish Autonomous Region of Catalonia is being dismantled through budgetary and service cutbacks. These cutbacks are resulting in obstacles in access and risks to peoples' health.

A coalition entitled Plataforma de Afectados por los Recortes Sanitarios, or PARS has filed a complaint for a possible criminal law violation to the Prosecutor General of Catalonia on March 21st to demand an investigation into extremely serious developments that are taking place in our Catalan health care system. This coalition includes anonymous citizens, law and health professionals, librarians, administrators, precarious workers, and the unemployed. Also on board are social justice, community, and patient organizations such as the Ostia Neighbors Association, Barceloneta Neighborhood Popular Associations, the Chronic Fatigue Syndrome League, a working group from Democracia Real Ya and other Occupy-type groups such as the Grup de Defensa de la Salud Publica. Prominent supporters include the former prosecutor Carlos Jimenez Villarejo, Rosa Regas (writer and former director of the National Library).

It is important to underscore that the aim of this investigation is to obtain a criminal, rather than civil, lawsuit against the Health Department of the

(continued on page 14)

LEGAL ACTION AGAINST THE CATALAN GOVERNMENT (continued)

Catalan government. Our case can be summarized in a few points:

Looming Privatization

The public sector is being dismantled at the service of private interests, with the intention not of improving or preserving the Catalan public health system, but of transferring public health resources to the private sector.

The deterioration of Catalan public health cannot be explained only as a result of the economic crisis. Rather the "anti-crisis measures" referred to by the Catalan government are being used to do additional damage to our public system with the aim of favouring private enterprises in which senior members of the Catalan government have personal economic interests. This criminal intent was openly revealed by the current minister of health, Boi Ruiz who warned that government measures would cause an increase in waiting lists while recommending affected citizens to purchase private insurance.

Conflicts of Interest

- Officials who are involved in this plot: Boi Ruiz; Roser Fernandez Alegre, Secretary General of health; Josep Maria Padrosa, Director of the Servei Català de la Salut; and Josep Prat Domènech, President of the Board of Directors of the Institut Catala de Salut.
- Boi Ruiz, just before becoming Minister, was President of the health sector Catalonian Employers' Association, which themselves define as a 'national and international opinion institutional lobby'.
- Josep Prat Domènech, President of the ICS, currently has several positions in the private health sector, including President of one of the largest international private health sector groups with a presence throughout the State - USP hospitals. Although he announced his resignation from this and other positions, his resignation is not included in official records. As documented in the complaint, Josep Prat currently receives income from nine positions in private healthcare companies.

The Right to Health

The deprivation of a civil right, such as the right to health, is a crime regulated by article 542 of our Penal Code, which states that the perpetrator "will incur in the penalty of disqualification from public employment for a period of one to four years, for the authority or public official who knowingly prevents a person from exercising the civil rights granted by the Constitution and the Law."

The complaint is a collective work embodied in 73 pages that make up the body of the complaint and 69 annexed documents; a total of about 450 pages. For the drafting of the complaint we have handled more than 120 papers and more than 220 articles and pieces of information from different media and sources collected during months by members of the platform.♦

For more information: see http://defensasanitatpublica.wordpress.com/2012/02/10/carles-muntaner-parla-sobre-privatitzacio-en-salut/ or http://afectadasporlosrecortessanitarios.wordpress.com/articulo-principal-esp/. If you want to join us in this collective action in the Tribunals follow the link Adhesiones.

STUDENTS FOR MEDICARE CONFERENCE (continued)

a conservative approach which delinks those two items. Review CCPA's 6% solution in the 2012 Alternative Budget. Always connect spending to outcomes. Private lobbying is also necessary in the form of relationship-building, with intelligence gathering to know how and when to advance campaigns like Doctors for Fair Taxation.

5. Develop your bedside manner with politicians. Train and strategize to avoid the booby traps of public presentation. In developing your message, keep the message short and simple and make sure it is tweetable.♦

For more information http://www.studentsformedicare.com/; www.progressive-economics.ca/

MRG MEMBERSHIP APPLICATION

I would like to ___become a member ___renew my support for the work of the Medical Reform Group

Membership Fees

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

Please specify membership category:

_____

Please specify areas of interest and expertise:

_____

_____

Name _____
Address _____
City _____
Province _____
Telephone _____
Fax _____
E-mail _____

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

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

You may pay your membership fees and supporting contributions through our monthly payment option by completing the following authorization and **enclosing a blank 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 _____ 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 (Please Print) | Account holder's signature | Date

STUDENTS FOR MEDICARE CONFERENCE

Students for Medicare held its 4th annual conference on Saturday March 31st, 2012. Approximately 80 new students and residents gathered for keynote talks by Dr. Gordon Guyatt, one of the MRG founders and a renowned McMaster University health researcher, and Armine Yalnizyan, senior economist at the Canadian Centre for Policy Alternatives, and frequent media contributor and blogger for the Progressive Economic Forum.

Guyatt focused his presentation for the morning session on addressing facts and myths on the sustainability of medicare, with a careful analysis of health spending over the past 20 years. Among his lessons to the next generation of health providers were:

- Concentrate on total health expenditures not just public expenditures
- Public funding of health care not only enhances equity, but is far more efficient than private funding.

After a brief introduction in which she set the context for discussion, Yalnizyan reminded delegates of 5 things doctors can do to enhance and maintain Medicare:

1. Use talents and networks to promote evidence-based decision making throughout the health care system.

2. Acknowledge that doctors are caregivers; capitalize on that virtue to promote equity, which might include social and not just health equity. Doctor as advocate is honourable and necessary.

3. Understand your power as highly trained and highly regarded professionals and use it often and collaboratively to speak to more equitable resource allocation. Pool your intelligence and resources

4. Public lobbying needs to be maintained, clearly linking taxes to services, in contrast to

(continued on page 15)

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 [e-mail]