

MEDICAL REFORM

Newsletter of the Medical Reform Group

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ROMANOW REPORT REMAINS UNFULFILLED PROMISE

Gordon Guiyatt

Roy Romanow has a new incarnation. The former Saskatchewan Premier and national Commissioner is becoming Canada's health care conscience.

It shouldn't have happened that way. When, just over a year ago, Romanow released his plan for rejuvenating Canadian health care he had already won high praise for the Commission's process. In twenty-one days of well-publicized public meetings, and a dozen day-long focus groups, Romanow mobilized the ordinary Canadians who are usually assigned a spectator role in major political decisions. The public response to Romanow's report demonstrated that he had listened well. His call for high-quality, publicly funded health care for all Canadians, delivered by not-for-profit providers, had broad appeal.

Romanow's recommendations were guided not only by Canadians' values, but by a sophisticated review of the relevant research concerning efficient, effective health care delivery. Romanow's practical, evidence-based recommendations drew both national and international attention. In September 2003, for instance, the report won Romanow a prestigious Pan-American Health Organization award.

Yet, a year later, governments have failed to fully implement a single one of Romanow's recommendations. Both

federal and provincial governments have let us down. The key to the Romanow report is more federal money directed to specific targets, with provincial accountability for how the money is spent. The February 2003 federal-provincial accord represented governments' first response to these suggestions. The accord delivered substantial new federal money to the provinces, though falling well short of Romanow's recommendations.

A substantial portion of the new money, \$16 billion, is targeted to three central Romanow goals: primary health care, home care and catastrophic drug coverage. But provisions to ensure that the provinces spend the funds as specified are virtually non-existent.

Another key Romanow recommendation, a strong Canada Health Council, might have provided the necessary monitoring mechanism. But an underfunded, unwieldy, politically dominated Council is all we are likely to get. As a result, it won't be up to the job. Romanow himself has been far from silent as he has watched political leaders squander Canada's opportunity to rebuild public health care. Awarded an Atkinson Fellowship to continue his health care research and advocacy, Romanow has expressed increasing impatience.

"There is a ton of major work to do and there is a time for action right now and it's overdue," Romanow told delegates to a nursing conference last month. "I'm simply saying as a danger signal, a warning signal, for the governments: act now, please."

Romanow's 47 recommended actions include reform of primary care, innovation in electronic medical records, and initiatives in aboriginal health services. The most important recommendations, however, are creation of publicly funded, nationally co-ordinated programs for prescription drugs and home care. At the moment, one can't find even a hint of forward movement on these proposals.

Despite all these frustrations, a conclusion that Romanow's work has had little impact on the Canadian health scene would be a major error.

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MedicalReform

Medical Reform is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at \$50 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>.

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

Editorial committee this issue: Rosana Pellizzari, Janet Maher.

The Medical Reform Group is an organization of physicians, medical students, and others concerned with the health care system. The Medical Reform Group was founded in 1979 on the basis of the following principles:

1. Health Care is a Right.

The universal access of every person to high quality, appropriate health care must be guaranteed. The health care system must be administered in a manner which precludes any monetary or other deterrent to equal care.

2. Health is political and social in nature.

Health care workers, including physicians, should seek out and recognize the social, economic, occupational, and environmental causes of disease, and be directly involved in their eradication.

3. The institutions of the health system must be changed.

The health care system should be structured in a manner in which the equally valuable contribution of all health care workers is recognized. Both the public and health care workers should have a direct say in resource allocation and in determining the setting in which health care is provided.

ROMANOW REPORT REMAINS UNFULFILLED PROMISE (continued)

When, early in 2001, the Romanow Commission began its work, proposals to move away from public funding for physician and hospital services were gaining increasing attention. Health care costs are exploding, universal care is unaffordable, private funding is necessary, the affluent should be able to pay for superior care - so the logic went.

The Commission considered these arguments seriously but ultimately rejected them. While the value Canadians place on equal access to high quality health care played a role in that rejection, the strong, consistent evidence that public funding of health care is far more efficient proved even more important.

As it turns out, Canadian expenditure on health care as a proportion of gross domestic product has been more or less stable over the last decade - out-of-control health care costs is a myth. Canada's single payer system results in far lower administrative costs than the mixed public-private American funding approach. Canadians spend \$307 per person per year, or 17 per cent of health care costs on administration. U.S. citizens pay \$1,059 each, or 31 per cent of their health care dollars.

Furthermore, in the areas of public funding, physician and hospital

services, Canada has held the line in spending. Areas of mixed funding, particularly prescription drugs, really do show exploding costs. The bottom line on efficiency of public funding is the relative costs of Canadian versus American health care: Canada still spends less than 10 per cent of its GDP on health care, while the U.S. spends over 14 per cent.

Romanow's report has meant that abandoning public funding for hospital and physician services is no longer a serious political option. Romanow's blueprint for a national health system based on federal-provincial co-operation and including expanded, publicly funded home care and pharmacare programs remains on the table.

As the flurry of publicity around his reports first anniversary has shown, Romanow remains on the public scene. The former Commissioner now represents the unfulfilled promise of a public health system that was once, and could once again be the world's best. ♦

First published December 10, 2003 as one of Dr. Guyatt's biweekly columns in the Winnipeg Free Press.

MRG PRESCRIPTION DRUGS BRIEF: A SUMMARY

Bradley MacIntosh

In the fall of 2003, the House of Commons Standing Committee on Health met with interest groups in 7 cities across Canada. On October 30th, members of the Medical Reform Group, Dr. Joel Lexchin, Dr. Rosana Pellizzari and the author, presented their brief. The focus of the Standing Committee was on “aspects of various issues relative to prescription drugs in Canada”. The following sections highlight the brief and the comments it stirred.

Rising and Control of Prescription Drug Costs

Between 1987 and 2001, the percentage of health care costs in Canada spent on prescription drugs rose from 7 per cent to 12 per cent of the total health care dollar. By contrast, the national drug benefit plans in Australia and New Zealand (PHARMAC) are doing a much better job at controlling drug costs. The MRG reiterated the potential savings to be realized if prescription drugs could be purchased in bulk by consortium of provincial and territory buyers (monopsony).

With respect to access to prescription drugs, the MRG conveyed the disparity that exists between low and high income groups when it came to out-of-pocket prescription drug expenditures. During the period 1984-1990, individuals in low income groups (under \$14,000) had out-of-pocket expenditures that were more than seven times as much as individuals in high income groups (over \$49,000), when measured as a percent of the total household expenditures. Presentation of these figures reminded the Standing Committee that relying on public/private mixtures of coverage is not a viable option of ensuring universal access.

Approval of New Drugs: Safety, Therapeutic Value and Transparency Cause for great concern ensued, described by one committee member as being “uncomfortable”, when the MRG presented data on safety of new drugs. In the U.S. nearly 20 million patients were exposed to at least 1 of 5 drugs that were withdrawn from the market between September 1997 and September 1999 for safety reasons. Three of these five products had been available for less than 2 years. According to an American meta-analysis, in 1994 over 2.2 million hospitalized patients had serious adverse drug reactions (ADRs) and over 100,000 had fatal ADRs making these reactions between the fourth and sixth leading cause of death.

MRG representatives explained that approval of new drugs by Health Canada is no guarantee that they are superior or even equivalent to existing drugs, primarily because Health Canada stipulates that the new drug must be superior to a placebo, and that it be relatively safe.

There is much insight to be gained from an international perspective, when Canadians evaluate the therapeutic value of new drugs. The French drug bulletin, *Prescrire International*, shows that, from 2500 new drugs identified between 1981 and 2001, only 3 per cent were rated as a major therapeutic gain, while 64 per cent were considered superfluous.

A second example comes from a series of studies conducted by Italian researchers. From 1995 to 2002, they studied new anticancer drugs (N=12), new central nervous system drugs (N=9), and new cardiovascular drugs (N=11). They concluded that in spite of a general trend showing no improvement in survival, nor an increase in the quality of life or safety, these new drugs cost more than the standard treatments.

The transparency and openness of the regulatory approval process in Canada needs significant improvement. Information about drugs going through the Canadian approval process is shrouded in secrecy. For instance, while a drug is in the regulatory process, the Therapeutic Products Directorate (TPD) considers the drug submission to be confidential.

The MRG recommended that Canada adopt a regulatory program that is similar to that in the United States, where there are open expert advisory panel hearings on most new drugs. Marketing and Promotion of Prescription Drugs

In a rare moment of unity, all Committee members present agreed that direct-to-consumer advertising (DTCA) was a bad thing for Canadians. This view was reinforced by reports which showed that the two inevitable products of DTCA are a rise in drug costs and an increase in the number of prescriptions.

Some startling numbers illustrate the significant role that advertising plays in the pharmaceutical industry:

- 1) the top 10 DTC advertising campaigns in 2000 spent US \$924 million in advertising, which resulted in US \$16,348 million in sales for the same year,
- 2) on average the top drug companies spend more on advertising costs than they do on R&D by factors of 2 to 3.

In Canada, according to the Food and Drug Act, DTCA of prescription drugs (but not over-the-counter drugs) is illegal. However, policy statements in 1996 and 2000 by Health Canada are clear steps to relax this law. Despite the fact that currently breaches of the Food and Drug Act often go un-penalized, if Canada were to “officially” legalize DTCA, thereby joining the short list of

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MRG PRESCRIPTION DRUGS BRIEF (continued)

two Western countries (U.S. and New Zealand), spending on pharmaceutical drugs would increase by CDN \$ 1.2 billion.

Proponents of DTCA are faced with the daunting task of explaining why it is that since its inception two decades ago there is no evidence to suggest that it will either improve prescribing or improve health outcomes. Masquerading advertisements as potential educational material is shameful. In the true spirit of providing information to Canadians, the MRG recommended that all prescriptions be accompanied by educational documentation written by an independent and regulated body.

In terms of promotion in Canada, pharmaceutical companies currently spend \$1.9 billion dollars per year promoting their products, with the overwhelming majority of that money

going to promotion to physicians. Although the data is not available, the MRG speculates the majority of this money is spent providing retail samples to doctors, as is the case in the U.S.

Furthermore, Canadian doctors interact with pharmaceutical sales representative an astonishing 4.2 times per week. Despite the fact that doctors feel that these interactions do not compromise their decision-making, using drug samples in their clinic leads to poorer prescribing.

Prescribing by Canadian Physicians

Although the issue of prescribing by Canadian Physicians was not covered explicitly in the Committee's mandate, co-author of the brief, Dr. Lexchin, has previously reported significant deficiencies in the prescribing behaviour of Canadian doctors.

In general, doctors tend to fall victim of poor prescribing when subject to drug promotion. Therefore, Canadian doctors would benefit from a bulletin service on prescribing information, as is available in British Columbia (The Therapeutics Letter) and other countries (Australia). Finally, some studies have shown that doctors who are not paid on a fee-for-service basis are superior prescribers compared to fee-for-service doctors.

The authors of the MRG brief were glad to be a part of a lively discussion that is critical to maintaining and improving the health of all Canadians and look forward to positive steps henceforth. ♦

For a copy of the brief or relevant references please contact medicalreform@sympatico.ca.

PLUS ÇA CHANGE...

In their brief this afternoon to the Commons Standing Committee on Health, representatives of the Medical Reform Group underline their frustration in following the prescription drug issue for past 20 years.

The brief covers two main areas, drug costs and the drug safety and approval process currently in force.

As student member Brad MacIntosh observed, "What we are presenting here is not rocket science, and not much of it is even very new. Canadians are looking for equity in health care, and looking for some clear accountability in the use of their taxes, and we just need to make the commitment once and for all to give them what they want."

"On the issue of costs," says Dr. Rosana Pellizzari, "our findings are

especially telling, and as the Medical Reform Group has already stated on numerous occasions, all Canadians should be assured access to prescription drugs, and universal pharmacare is absolutely central to providing equal access to all Canadians."

The MRG analysis shows that, central to the issues of both drug costs and drug safety in Canada is the proprietary approach we have which makes it very difficult to substantiate the claims for new drugs—how much better or worse or how much more or less expensive they might be that what has gone before?—without access to all the clinical data and analysis used in the regulatory process.

According to Dr. Joel Lexchin, "until we can make it possible to have public access to this information used in

the drug approval process as a matter of public policy, Canadians will continue to be kept in the dark." ♦

Released October 30, 2003

BRIEF TO HOUSE OF COMMONS STANDING COMMITTEE ON HEALTH: EXECUTIVE SUMMARY

Joel Lexchin, MD, Rosana Pellizzari, MD, MSc, CCFP, Bradley MacIntosh, MSc

The Standing Committee met in Toronto on October 30, 2003 to hear submissions for its study on the health aspects of various issues relative to prescription drugs (patented and generic) in Canada, such as the rising costs; the review and control of prices; the approval of new drugs; the monitoring of adverse effects and prescribing practices; the marketing to and lobbying of prescribers and dispensers; direct-to-consumer advertising; the access to drugs; the misuse, abuse and addiction within the general population; and international comparisons.

Executive Summary

The Medical Reform Group of Ontario (MRG), formed in 1979, is a group of about 300 practicing physicians and medical students.

The MRG represents the views of its members on health and health care matters through research, public statements and consultation with other groups who share our aim of maintaining a high quality publicly funded, universal health care system. The MRG believes that health is political and social as well as medical in nature and that health care is a right.

The Medical Reform Group of Ontario is pleased to be able to appear before the Standing Committee on Health on the matter of prescription drugs. The MRG has been active in this area for over 20 years starting with the Eastman Commission in the early 1980s and including Commons and Senate hearings on Bills C-22 and C-91.

We believe that the question of prescription drugs is extremely

important for a number of reasons. Modern medications have the potential to greatly improve the lives of Canadians but that potential can only be realized if drugs are affordable both to the individual and to the country, their effectiveness and safety is well understood, they are promoted in a responsible manner and they are prescribed appropriately.

Our examination of the evidence concerning prescription drugs leads us to conclude that there are serious problems in all of these areas.

Our presentation today will demonstrate to the Committee our concerns with a wide range of issues including:

- ◆ Rising costs of prescription drugs and how to control both overall spending on medications and ensure that all Canadians have access to them;
- ◆ The regulatory approval system for new drugs;
- ◆ The safety of medications;
- ◆ The effectiveness of medications;
- ◆ The prescribing of medications;
- ◆ The Promotion of medications to physicians and to consumers.

Recommendations

1. With respect to Rising Cost and Control of Prescription Drugs:

- ◆ There are potential savings to be realized if prescription drugs could be purchased in bulk by consortium of provincial and territory buyers (monopsony).
- ◆ All Canadians should have access to prescription drugs as part of universal Pharmacare.
- ◆ Evidence based cost-efficient prescribing needs to be supported

to promote use of effective, lower cost drugs by physicians.

◆ Provincial governments should use their substantial buying power to reduce drug spending to levels comparable to those in Australia.

◆ All provincial governments should use practices such as competitive tendering and reference based pricing to lower overall drug spending.

◆ All Canadians should be assured of access to prescription drugs. Relying on a public/private mixture of coverage will limit the possibility of controlling spending and promote regressive subsidies. Canadians should be covered through a public drug plan.

2. With respect to Approval of New Drugs

◆ The transparency and openness of the regulatory approval process in Canada needs significant improvement. Canada should move to a system similar to that in the United States where there are open expert advisory panel hearings on most new drugs. At these meetings other interested parties, including members of the public are given time to speak.

◆ All clinical data submitted by pharmaceutical companies during the regulatory approval process should be available to interested parties as a matter of right without the ability of the companies to block access. (Patient identifying information and any information involving proprietary manufacturing procedures should be

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BRIEF TO HOUSE OF COMMONS STANDING COMMITTEE ON HEALTH (continued)

removed before the information is released.) The evaluations of this clinical information by reviewers from the Therapeutics Products Division (TPD) should be publicly available.

◆ The post-marketing surveillance system in Canada should be constructed to achieve the four objectives outlined by Moore et al: 1) estimating the number and causes of serious injuries and deaths, 2) identifying new serious adverse reactions, 3) monitoring the effect of previous safety alerts and 4) operating an early warning system.

◆ The TPD must be given adequate resources to undertake a comprehensive post-marketing surveillance system. These resources should come from public funds not from the pharmaceutical companies.

◆ Post-marketing studies required by the TPD to assess safety should be mandatory. Sanctions for not undertaking and completing these studies within a reasonable period of time should include the withdrawal of the drug from the market.

◆ As part of the approval process, the TPD should require pharmaceutical companies to compare new drugs to appropriate existing therapies.

◆ New drugs should only be approved if they can be shown to have some advantage (better effectiveness in the general population or in specific subpopulations, better tolerability, better safety profiles, etc.) over existing therapies. Norway had such a system from 1928 to 1996 when it harmonized its regulatory system with that of the European Union.

There was no evidence that medical care in Norway suffered as a result of this requirement.

◆ All drugs should be reassessed for effectiveness and safety after they have been marketed for 5 years. The European Parliament and European Commission have recently agreed to such a standard for drugs approved through the central European system.

3. With respect to Promotion and Marketing of Prescription Drugs

◆ Health Canada should no longer allow voluntary self-regulation of promotion by the pharmaceutical industry.

◆ All pharmaceutical promotion should be under the control of an independent agency established through legislation, similar to the Canadian Radio and Telecommunications Commission. Appointments to this new body should be independent of the pharmaceutical industry. This new body would establish regulations to control promotion that would be mandatory.

◆ There should be proactive monitoring of all promotional activities with open reporting about violations of the regulations. There should be a system of escalating sanctions of increasing severity for repeated violations of the regulations, taking into account the nature of the violations.

◆ Canada's position on ethical marketing of pharmaceutical drugs nationally should be consistent with its position internationally, as demonstrated at the World Health Organization. From assemblies in 1988 to the present date, Canada has expressed support for guidelines that clearly statement

advertising must not be disguised as an educational activity.

4. With respect to Prescribing by Canadian Physicians

◆ Canadian doctors need ready access to up-to-date objective sources of prescribing information. One such bulletin is published in British Columbia, the Therapeutics Letter. Resources should be made available so that this publication can be distributed for free to all Canadian doctors similar to the free distribution of the Drug and Therapeutics Bulletin in the United Kingdom.

◆ In a previous section we documented the negative effects of promotion on prescribing. Once again we emphasize the need for a much stricter method of controlling promotion.

◆ Methods such as academic detailing (having trained personnel, usually clinical pharmacists visit doctors to discuss specific prescribing practices) have been shown to not only be effective in improving prescribing but also to save money. There is a fledgling network of academic detailing in Canada. This network should be provided with resources to expand its activities to cover the entire country.

◆ Some studies have shown that doctors who are not paid on a fee-for-service basis are superior prescribers compared to those on fee-for-service. Given this finding, doctors should be encouraged to explore alternative payment methods.

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BOUTIQUE MEDICINE

Irfan Dhalla

As reported in Issue 127, Steering Committee member Irfan Dhalla has led the monitoring of the Block Fees Policy of the College of Physicians and Surgeons. We reproduce below the text of his September 5th brief to the College.

Thank you for providing the Medical Reform Group with an opportunity to participate in the review of the block fees policy.

As has been noted in a recent issue of Dialogue, there have been numerous documented instances of doctors violating the block fees policy. The article noted that the College has received complaints regarding:

- ◆ a psychiatrist charging patients to review their daily logs
- ◆ patients from one town being told that their physicians would drop them from his/her practice if they did not pay the block fee
- ◆ patients from another town being told that unless they paid a block fee, their telephone messages would go unanswered

We suspect that many more similar cases go unreported.

Even more disturbingly, a recent Globe and Mail article describes two family physicians who are charging their patients a \$2500 annual fee for “a detailed medical workup,” “a customized health care plan,” and “24/7” access. The two are aiming for practices with 150 patients each, rather than the customary 2000 or so. This kind of practice has been referred to

in the United States as “boutique medicine” or “luxury primary care.”

The current block fees policy does not explicitly bar boutique practices. We suspect that the two doctors charging their patients \$2500 per year have structured their fee so as to avoid technical violation of the block fees policy. Nevertheless, the Medical Reform Group feels that boutique practices violate the spirit of the block fees policy, and that a revised policy should clearly and explicitly bar boutique practices.

With thousands of Ontarians unable to find a family doctor, it is irresponsible and perhaps unethical for physicians to limit their practice to a few patients who pay exorbitant fees for medically unnecessary care. The College, in defending the public interest, should not allow this situation.

Moreover, the caring aspects of medicine, including acting as a patient advocate and giving customized advice, are appropriately interpreted as part of covered services. Therefore, doctors should not be allowed to charge for those services. Boutique medical practices thus violate codes of ethics and perhaps even the law.

The Medical Reform Group steering committee has extensively discussed the block fees issue via e-mail and at its September meeting. Clearly doctors are permitted to charge patients directly for services not covered by OHIP. We believe, however, that doctors should be permitted to charge for these services only individually, as they are provided.

Block fees will inevitably open the door to some degree of boutique medicine, whether in the extreme versions described in the Globe and Mail, or some less egregious manifestation. In permitting boutique medicine, block fees likely result in patients being

discriminated against (for example, receiving less of the doctor’s time at appointments, receiving less advocacy when they need an MRI, etc.) if they do not pay the fee.

Because of difficulty with monitoring, as well as patients’ reluctance to complain because of feelings of dependency and intimidation, a block fees policy designed to limit the damage is unlikely to be successful.

Therefore, the Medical Reform Group believes that the College of Physicians and Surgeons of Ontario should prohibit block fees.

If the revised policy does permit block fees, we suggest tightening the policy to limit boutique practices and discrimination. Specifically, we suggest the following:

- ◆ A revised policy should have a longer preamble, clearly outlining what kinds of services patients cannot be charged for.
- ◆ Doctors who offer patients the block fee option should be required to post in their office a CPSO-designed poster outlining what services cannot be included in the block fee. This poster should also explain how patients could file a complaint if they feel their doctor is violating the policy.
- ◆ A revised policy should clearly state a doctor must not discriminate between patients, neither in terms of accepting them in to their practice, nor in terms of the quality of OHIP-covered care provided, on the basis of their willingness to pay the fee.
- ◆ A revised block fees policy should specify a maximum allowable block fee. This fee should reflect the value of non-OHIP services included in the block fee

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BRIEF (continued)

In Australia the government has funded an independent National Prescribing Service at a rate of about \$6 million per year. Canada should study this Australian model with a view to establishing a Canadian equivalent. ◆

HOLDING THE NEW ONTARIO GOVERNMENT ACCOUNTABLE FOR ITS PROMISES

The Medical Reform Group wrote the new Ontario Health Minister days after his appointment to urge him to keep the government promise to rescind the Public Private Partnerships initiated by the previous government in Brampton and Ottawa. At press time, negotiations for the meeting are on-going.

November 10, 2003.

Hon. George Smitherman
Minister of Health and Long Term Care
10th Floor, 80 Grosvenor Street
Toronto, Ontario
M7A 2C4

Attention: Anna Starnino

Fax: (416) 326 1571

Dear Minister,

Re: P3 hospitals

I am writing to request an urgent meeting on the issue of the public-private partnership agreements under which the previous government proposed to build new hospitals in Brampton and Ottawa, a decision the new Premier committed to reverse during and since the recent election campaign.

In addition to the information already forwarded to you last week by a group of economists led by Lewis Auerbach [summary attached], several of our members have been involved in the past year or so on some very critical research on outcomes in for-profit and not-for profit settings, which may be important for the decision you are about to make on the above issue. ♦

BOUTIQUE MEDICINE (continued)

(for example, telephone advice, telephone prescription reviews, form completion, etc.) and should be no more than \$100.

In summary, the Medical Reform Group believes that the CPSO should ban block fees. If block fees continue to be permitted, we suggest several additions to the block fees policy. These changes would help ensure that all Ontarians continue to have access to high-quality medical care.

Thank you for the opportunity to participate in the block fees policy review. Please feel free to contact us if you would like more information or clarification of our position. ♦

KEEPING THE PROMISE

On November 13, 2003, Gordon Guyatt followed up on the Steering Committee request to the Minister of Health with a more explicit submission to the Premier and members of the Cabinet policy and priorities committee as follows:

I am writing to urge you and your cabinet colleagues to maintain in government your election campaign commitment to increase needed hospital services in our province without recourse to the for profit (P3) strategy planned by your predecessors.

The Medical Reform Group believes the voters of this province chose change on the basis of some very thoughtful analysis particularly of the situation of health services in our province. To disappoint them by returning to the Tory strategy is not only bad economics, but risks alienating the most important people in this province—the voters who have given you such an extraordinary mandate to do things differently and better than the government you replaced.

As your party noted during the election campaign, the so-called “saving” to the public purse by privatizing the finance, operation and ownership of hospitals is really a false economy. The world-wide evidence is clear. Public audit offices in Britain, PEI, Nova Scotia, New Brunswick, Australia and the government of Canada have all reported that P3 hospitals do not save money, they cost more. The off-book accounting that characterizes P3 schemes may hide the debt
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KEEPING THE PROMISE (continued)

temporarily from public scrutiny but it does disappear for the next generation of Ontarians. This type of accounting has been entirely discredited by the Enron fiasco and needs to be rejected forthwith.

Not only do P3 hospitals cost more, the high costs associated with this model of redevelopment on the capital side are often accompanied by cuts in operating and clinical budgets, including, on average, 26 per cent staff cuts and 30 per cent bed cuts, according to a recent item in the *British Medical Association Journal*.

You will have already received a brief from a group of eminent Canadian economists including Lewis Auerbach, Arthur Donner, Douglas D. Peters, Monica Townson, and Armine Yalnizyan calling for the immediate cancellation of the P3 deals and a commitment to the public financing of new hospital infrastructure.

Their arguments about increased costs and loss of accountability in the P3 hospitals echo those made by advocates for quality public health care for years, and they also recommend your government move to an accrual accounting system to eliminate the systemic bias against public investment in infrastructure, and remind us all that low interest rates make it a good time to invest.

We believe Ontarians are interested and fully capable of understanding the financial arrangements being made on their behalf, and we think it will serve you well to engage them in a transparent policy exercise around health care funding, beginning with the funding of infrastructure. We urge you to make a full public disclosure of the funding arrangements for these projects.

We look forward to meeting with you at your earliest convenience to discuss ways to improve the quality of health care for all Ontarians. ♦

P3S ARE NOT THE ONLY FOR PROFIT HEALTH CARE SERVICES WE NEED TO GUARD AGAINST

The Medical Reform Group is encouraged by the Friday announcements of the new Premier and Health Minister regarding construction of two badly needed hospitals in Brampton and Ottawa.

Said Dr. Rosana Pellizzari, “We will of course be holding the government to its promise to make the contracts public, and we will be examining those to be sure that the government has got the best value for our money.”

“At the same time,” noted Dr. P.J. Devereaux, principal investigator on a recent series of analyses of for profit and not for profit health services, “we continue to be concerned that the government has not enunciated a clear policy on health services, and that there has so far been no mention of the fate of the former Tory government’s proposals to sign agreements with for profit operators for equally important MRI and CT scanning services.”

He continued, “We have asked to meet with the Minister of Health on an urgent basis, and will be seeking assurances that the government will apply the same logic to specific health services as to hospital construction. ♦

Released November 24, 2003

FUNDING HOSPITAL INFRASTRUCTURE: WHY P3S DON'T WORK, AND WHAT WILL--

SUMMARY

Lewis Auerbach, Arthur Donner, Douglas D. Peters, Monica Townson, and Armine Yalnizyan

A group of prominent economists and a former director with Canada's Auditor General have written to the Honourable Ministers of Health and Long Term Care, and Public Infrastructure Renewal commending the government for having rejected the P3 model, and encouraging the government to carry through by cancelling these outstanding projects.

In support of their position, the experts have prepared a report which examines the consequences of adopting a “public-private partnership” or “P3” model for providing health care infrastructure and services. It exposes the fallacies of the rationale offered for adopting this approach, and describes the significant cost premium and accountability problems associated with the P3 model.

The experts describe the consequences of adopting the P3 for public hospitals as including:

- ◆ a substantial premium that taxpayers will pay for hospital facilities and services that are likely to be 10 per cent more costly than hospitals that are publicly financed, owned and operated;
- ◆ the likelihood that the extent and quality of services will decline in P3 hospitals as efforts are made to sustain profit margins in an environment where efficiency gains are limited;
- ◆ the accountability problems inherent to P3 projects where confidentiality is claimed for financial and business records, preventing a proper accounting for public health-care spending, and frustrating efforts to monitor P3 hospitals for compliance with the principles and objectives of the Canada Health Act;
- ◆ the risk that by introducing the profit motive to public hospitals, P3s will create a platform for two-tiered service because of the co-mingling in one institution of insured health care services with

those provided outside the publicly funded system.

The authors also express their support for the traditional approach to funding public infrastructure. They describe the public funding model as perfectly sound so long as accounting for such investments is improved.

To this end they call upon the new Government to adopt an accrual rather than a cash method of accounting for investment in health care infrastructure so that the costs of acquiring an asset like a public hospital can be spread over its useful life. They note that with interest rates at historically low levels, and significant unemployment in the province, the time is ideal to invest in hospitals and infrastructure.

Background

In December 2001, Ontario's Conservative government announced plans to establish two private hospitals on sites owned by the William Osler Hospital Centre (WOHC) and the Royal Ottawa Health Care Group (ROHCG).

According to a scheme it described as a “public-private partnership” or “P3”, the Government proposed that both hospitals would be privately financed, owned, and operated. In addition to providing hospital buildings and facilities, these P3 deals would bundle all “non-clinical” services into long-term contracts with for-profit health care companies. According to the Government, clinical care services would remain under the control of the existing hospital boards.

In making these announcements, the Government signalled its intention

to abandon the non-profit model for providing hospital services in Ontario, where for decades public hospitals have been publicly financed, owned and operated on a non-profit basis. Capital funding for hospital infrastructure was provided by grants from the provincial and federal governments, and private charitable donations.

On the eve of the recent election, both the WOHC and ROH signed “framework agreements” with the same consortium of domestic and foreign investors. Neither the provincial government nor the hospitals were willing to disclose the details of these arrangements. However the WOHC has indicated that in its case the P3 contract has a value of \$1.28 billion, and a term of twenty-eight years.

However the framework agreements signed by the Hospitals are contingent upon provincial approvals which have not yet been granted. Moreover, during the election campaign, the Premier indicated that he would not, if elected, carry through with these P3 initiatives. ◆

See the full brief at www.policyalternatives.ca

PROFITS FROM PAIN: A STORY OF HEALTH CARE IN THE U.S.--FALL MEMBERS MEETING

During her recent visit to Canada, Dr. Steffie Woolhandler led a discussion December 16th for Medical Reform Group members, entitled, "Profits from Pain: A Story of Health Care in the U.S."

Her presentation focused on her recent work on health care administrative costs in the U.S. and Canada, which was published in August, 2003 in the *New England Journal of Medicine*.

The study, conducted with Dr. David Himmelstein (Harvard Medical School) and Terry Campbell (Canadian Institute for Health Information) found that U.S. administrative costs in U.S. health care consume at least 31 cents of every health care dollar. Canada spends about 16.7 per cent of its health care dollars on administration.

This work provides detailed estimates on health administrative spending by insurance companies, private employers, hospitals, nursing homes, doctor's offices, and home care agencies. Dr. Woolhandler addressed both the methodological issues and policy implications of this work, as well as commenting on their ongoing study on the role of illness and medical bills in causing consumer bankruptcies in the United States.

That study has found that illness causes (in whole or in part) about half of the 1.5 million personal bankruptcies filed in the U.S. annually. Surprisingly, most persons experiencing medical bankruptcy were middle class by occupational and educational criteria, and had health insurance at the onset of their illness.

She noted that the past decade has seen the rapid introduction of market forces and for-profit ownership in U.S. medical care. There is dis-

turbing evidence to suggest that this trend is compromising care, and stimulating undesirable, and even unethical and illegal practices.

The number of un- and under-insured Americans has increased sharply despite expansions of public coverage. The doctor-patient relationship is being severely undermined by profit-based incentives offered doctors and pressures to increase throughput. U.S. health status measures are falling further behind those of other developed nations.

A few giant for-profit HMO firms increasingly control the market, threatening oligopoly. Surveys show substantial patient dissatisfaction with managed care, particularly among poor and other vulnerable patients - exactly the patients being pushed into managed care. Outcome studies suggest that these vulnerable groups fare poorly even in relatively good HMOs.

Meanwhile, managed care plans and other for-profit health care firms have been plagued by repeated scandals, and studies show that for-profit care is costlier and less efficient. Risk-avoidance by HMOs and insurers is endemic, even when banned. Denial of needed care is a common problem. For-profit hospital chains have systematically abused patients for financial gain, and commonly ignore community needs that conflict with the firm's financial interests. For-profit nursing homes have a particularly disturbing record of labor-law violations and poor quality care, and the for-profit dialysis industry has produced poor care and high costs.

The growing corporate ownership and control of medicine are creating far more problems than they are solving. The administrative costs of enforcing inequality in access to care and assuring profitability are huge, amounting to nearly one-third of U.S. health spending.

Efforts to regulate profit-driven abuses have thus far met little success.

Similarly, it appears that initiatives to measure and reward quality have been effectively undermined by incentives to circumvent these measures, or to focus narrowly on the few aspects of care that are subject to measurement.

Health professionals and patients are increasingly vocal in opposing for-profit medicine and the commoditization of care. Recently, more than 11,000 U.S. physicians have endorsed a proposal for a Canadian-style national health insurance program for the U.S. ♦

Steffie Woolhandler, M.D., M.P.H., is a leading health policy researcher and advocate of universal, non-profit health care for the United States. She grew up in Shreveport, Louisiana, and holds degrees from Stanford University, Louisiana State University, and University of California at Berkeley. Her research includes investigations on administrative costs in the U.S. and Canada, inequalities in care, and the quality and cost outcomes of investor-owned hospitals, HMOs and nursing homes. She has authored more than 75 peer reviewed publications. In 1986, she co-founded, along with David Himmelstein, Physicians for a National Health Program, a group of over 10,000 U.S. physicians who advocate national health insurance. She was lead author of a proposal for national health insurance that appeared this summer in the JAMA. She lives in Cambridge Massachusetts, where she is co-director of Harvard's general internal medicine fellowship program and Associate Professor of Medicine at Harvard.

TORONTO STUDENT CHAPTER LAUNCHES

On September 17th, Toronto student members of the Steering Committee hosted a lively panel discussion, moderated by Gary Bloch, a family medicine resident at St. Michael's Hospital. Entitled "Making Change: Activism and Advocacy in Medicine, the forum included:

- ◆ James Orbinski, past president of *Medecins Sans Frontieres*
- ◆ Philip Berger, Chief of the Department of Family Medicine at St. Michael's Hospital and well-known Canadian political activist
- ◆ Danielle Martin, outgoing president of the Canadian Federation of Medical Students

A panel of seasoned international, national, and local socially active physicians spoke of their history of activism, exploring how and why health care providers must engage on a social level to provide optimal health care for their patients. Long time member Philip Berger forwarded his speaking notes, which we reproduce as a reminder of the multiplicity of daily situations physicians face in which they can make a difference.

Good evening and thank you for inviting me to speak today. I will try in my own inadequate fashion to pass on to you some of the lessons that I've learned, mostly from patients, about physician activism.

To begin with, let me tell you about an interesting phone call I received a while back. Almost one year ago I was a speaker, along with George Smither-man – the local member of the Provincial Parliament for the area in which St. Michael's Hospital is located – at a session held during the Gay and Lesbian Medical Association's annual meeting in Toronto.

A reporter from Xtra! Magazine – Toronto's leading gay and lesbian news publication – called me in preparation for a lead-up story to the conference. He asked me what obstacles gay and lesbian physicians face in the workplace. But before I could answer that question, he said he had another question to ask first. I anticipated what was coming, but decided to let him proceed without interruption. He cleared his throat, issued a few umms and ahhs, hesitated for a brief moment and finally blurted out "are you a gay physician?"

Well, just to set the record straight, so to speak, I told the audience I was not a gay physician and I politely explained to the reporter that I was in no position to speak on behalf of gay and lesbian physicians on any matter affecting their lives.

I first learned about the persecution and personal oppression of gay men from an openly gay physician with whom I worked for a year in the mid-1970's. His name is Dr. Wesley Friesen and he is now a psychiatrist in Vancouver, British Columbia. We were in the same

medical class together at the University of Manitoba in Winnipeg and at our 1974 graduation party, he came accompanied by his then-partner. Quite a daring act for a medical student in Winnipeg, not exactly the most friendly of places for gays in 1974.

During our year of working together, Wesley and I spent a lot of time talking and in particular about his life as a gay man. Although he has no recollection of these discussions, he permitted me to ask any question I wanted – and he provided answers which not only revealed the incredible discrimination he had encountered but de-mystified for me the erroneously-called homosexual lifestyle. These discussions had a profound effect on me and eventually led to my working at Hassle Free Clinic in 1977 which served many gay men.

Wesley's consciousness-raising also propelled me onto the streets in demonstrations against Anita Bryant – the orange juice poster girl and homophobe who brought her hatred to Toronto in 1977.

The lesson here is not to underestimate the powerful influence of one-to-one exchanges with colleagues who are prepared to listen. You might create a straight activist as in my case and an ally in the fight against homophobia. The other lesson is to guard against paternalism – speaking on behalf of others rather than following their lead. Another story and perhaps another lesson. It has to do with HIV/AIDS. In the late 1970's and early 1980's, a group of about a dozen downtown Toronto physicians had large numbers of gay men and some injection drug users in their medical practices.

I was one of those downtown physicians. Each of us had patients who experienced a fair number of sexually transmitted diseases. We also had patients who presented to us with weird infections similar to mononucleosis – fever, rash, sore throat, swollen glands and minor laboratory abnormalities.

These peculiar infections resolved, never having been diagnosed and we, the physicians, just attributed this temporary illness to yet another infection. Yet an epidemic – the AIDS epidemic – was occurring before our eyes. We did not, we were never trained to, gaze beyond the individual patient and identify in the case of AIDS, the biological circumstances that were making our patients sick – in our situation, the circumstance being a virus later identified as HIV. The lesson of looking beyond the patient can be applied to non-biological conditions, whether political, economic or social – if we look.

Speaking of AIDS, let me tell you another story, about a woman who I will call "Sharon" and her husband. Sharon came to Toronto from Nova Scotia in the early 1980's and became addicted to heroin shortly after her arrival. She was the second patient for whom I prescribed methadone – that was in late 1991.

Methadone is a treatment for heroin addiction and is unsurpassed in effectiveness. It is itself highly addictive but it is legal. Methadone is a liquid drug which is mixed with orange juice. It is taken on a daily basis by heroin addicts. It prevents withdrawal

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TORONTO STUDENT CHAPTER LAUNCHES: BERGER ON ACTIVISM (continued)

symptoms and eliminates cravings in people addicted to heroin.

As a result, heroin addicts do not use or share needles. Numerous studies have shown the benefits of heroin addiction treatment with methadone including a decrease in mortality rates and a reduction in crime and disease, including HIV, Hepatitis B and Hepatitis C. In fact, the prevalence of HIV in methadone treated heroin addicts ranges in the 5-10 per cent number in contrast to the 50 per cent or 60 per cent among those addicts for whom methadone is unavailable.

Sharon remained on methadone and abstinent from heroin – until her pain from AIDS required a switch to a continuous morphine infusion which she took until her death. She had been struck with a debilitating peripheral neuropathy – a condition which produced a fiery-like pain down her legs and eventually paralyzed her. Sharon died from Progressive Multifocal Leuko-encephalopathy or PML – an unusual AIDS complication which punches holes at random in peoples' brains. She died hallucinating and in a psychotic state. She also died at home, in my neighbourhood, 6 blocks from where I live. She died, as they say, in my own backyard.

Sharon stayed on methadone for the last 2½ years of her life. Once off heroin, she became as the preachers would say, repentant. She sought the solace of religion and God. She had been raised in a fairly devout and loving Catholic family and she reunited with her family a few months before her death. She could have been a member gone astray of your family or mine. It was the availability of methadone in a context of a comprehensive treatment program even with her HIV infection that permitted a

somewhat normal life and reconciliation with her family prior to her death.

Addicts are unlike any other patient group. They are an atomized community without leadership and organization equivalent to that of other patient communities. The absence of an effective addict lobby group means that governments, institutions such as the judiciary or health care organizations, are not held accountable.

Within a few months after I began to prescribe methadone in 1991, our medical office was flooded with phone calls from heroin addicts desperate for methadone treatment. We could in no way meet the demand. I and a nurse with whom I was working organized a widely covered press conference at Queen's Park at which 3 addicts and I spoke publicly about their addiction and the unavailability of methadone treatment. I remember that press conference because at the beginning I had to indicate that I was the doctor and that the other 3 were the junkies. So much for stereotypical addicts – or doctors, I suppose.

The press conference was quite successful, even resulting in a Globe and Mail editorial calling for more methadone spots. But the provincial government would not budge and described methadone as a controversial treatment.

The number of calls to our office kept increasing and finally it occurred to me and others that the Ministry of Health should hear these cries for help directly – after all, the state is responsible for administering health care including addiction treatment. Let Ministry representatives listen to what our office secretaries and physicians were hearing.

In the spring of 1992, Sharon and her husband, who has also since died of AIDS, engaged in a brief political campaign to increase the availability of methadone.

The couple stapled notices in public places across the city of Toronto

on a Saturday morning – particularly in places where heroin use was widespread. My only contribution was to purchase the staple gun and to provide the use of our office xerox machine. The notices said that methadone was the best treatment for heroin addiction. They further said that if you want methadone, phone the Deputy Minister of Health, at that time Michael Decter. His inside office phone number was printed on the notice.

Well, I have to tell you that Mr. Decter's office was inundated with phone calls from heroin addicts for the next six weeks or so. The two patients had instructed the government in the most palpable of fashion about the desperate need for methadone treatment.

In fact, Michael Decter left a message on my voice mail that same Saturday that the posters went up. He wanted an urgent meeting with myself, the nurse with whom I worked and some heroin addicts. We met the next Tuesday morning - three days after the posters went up.

Sharon was at that meeting and had a profound effect on Mr. Decter. So much so, that Mr. Decter promised to fund at least 100 more methadone spots in the City of Toronto and this was done a few months later. This couple had a major impact on provincial policies and indeed the number of methadone spots in Ontario has increased by 80 times more than the original 100 spots promised by Mr. Decter.

Sharon's story illustrates the political strength and benefits which can arise when health care professionals join with patients in the struggle for justice in health care.

Opportunity for actions can even lie in wholly unlikely circumstances.

In May, 1996 a member of Canada's Parliament from a very right-wing party made comments that suggested a link between homosexuality, and disease and pedophilia. The

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TORONTO STUDENT CHAPTER LAUNCHES: BERGER ON ACTIVISM (continued)

parliamentarian was a physician and in the view of many, including myself, had abused his status as a physician to promote hatred against a minority group.

I and two other physicians held a widely covered press conference to denounce the physician parliamentarian's statement. Thereafter a lawyer from Alberta, the physician's home province, laid a complaint to the College of Physicians and Surgeons of Ontario. The complainant demanded that our licenses be suspended for criticizing the right-wing physician.

As you can imagine, such complaints can be intimidating for physicians. Instead, we used the complaint process to formally and legally enunciate the basis for our actions and to describe the pain and damage the parliamentarian's statement inflicted on the gay and lesbian community. We invoked our duty as health care professionals to speak out against bigotry hiding under the respectability of a medical degree.

In Ontario, the complaint process is not public. It only becomes public if the complaint is referred to the Discipline Committee which holds public hearings. The complaint against us was dismissed.

To be honest, I had actually told the College of Physicians and Surgeons that I plead guilty and please could they refer the matter to the Discipline Committee so we could have a public debate on the parliamentarian's comments and our right to denounce them.

The College official said, "I'm sorry Dr. Berger, we cannot accommodate you" and he apologetically told me that the College could not accept my plea of guilty and, as mentioned, the College dismissed the charge.

I raise this as an example of how a scary proposition such as an investigation under our regulatory and licensing body

can be turned into an opportunity for political action.

Finally – on what basis does our responsibility arise to take political action in support of our patients? In my judgement, the answer can be found in the debate over who owns medical knowledge.

In the spring of 1986 during the lead up to the withdrawal of services by Ontario physicians, I attended a local Ontario Medical Association meeting - it was a tense, hot gathering. As members departed, I overheard one physician railing that "I own my medical knowledge and I will do what I want with it".

The physician, perhaps unwittingly, expressed a view that his knowledge was a commodity that could be bought like artwork, restaurant meals or clothing. The owner of the commodity, in this case the physician, could unilaterally set a price to his services, withdraw his services, and decide who to serve. Such a proprietary view of medical knowledge naturally and logically leads to physicians acting in their own self-interest, devoid of any responsibility to use their knowledge in support of the social or economic interests of their patients.

All polls indicate that Canadians have a different opinion on ownership of medical services. Health care has been accorded the highest social value by Canadians, equivalent in stature to the rights protected under the Canadian Charter of Rights and Freedoms. That value and right can only be sustained by the premise that medical knowledge is owned by the citizens and is held in trust by physicians to be used for the benefit of all citizens, a premise contrary to the marketplace or proprietary view of medical knowledge.

If one accepts the view that citizens own medical knowledge and entrust that knowledge to health care professionals, it means that we as health

care professionals have a duty to use our stature and expertise to engage the social and political processes in defence of our patients health interests.

So, the lessons:

- ◆ One on one conversations can be powerfully influential
- ◆ Be careful to avoid the trap of paternalism, not only of course in the practice of medicine, but in the politics of medicine
- ◆ Look beyond the patient for the conditions which produce illness; be they biological or political
- ◆ Join with patients in political interventions and actions
- ◆ Seek opportunities for political action even in improbable circumstances
- ◆ Finally, remember that flowing from the trust provided to physicians by society is a duty to act politically in defending the interests of patients.

A concluding remark. One of the original leaders of gay liberation in Canada was a man named George Smith. He was also one of the founders and leaders of AIDS activism in Canada and he died of AIDS a number of years ago.

George was an academic, a full professor at a Toronto university. He always raised the slogan of "documents and demonstrations" with respect to the fight against AIDS. Many members of the Medical Reform Group have become academics and as such, publish and produce a lot of articles and documents. Perhaps now is the time – as an organization – for the Medical Reform Group to join the demonstrations. After all, revolutions have never depended on or waited for randomized controlled clinical trials.

Thank you for listening to me. ◆

NATIONAL HEALTH COUNCIL: THE ON-GOING SAGA

DO NOT BE DETERRED: MRG URGES MINISTER TO SET UP HEALTH COUNCIL

The Medical Reform Group wrote Minister Anne McLellan today, encouraging her to move on the Romanow Commission recommendation to enhance accountability of the health care system by establishing a National Health Council without further delay.

Said member Dr. Rosana Pellizzari, "We applaud the strong leadership you are providing to ensure that the health care system in Canada becomes more accountable and effective, and we join with our colleagues in the Canadian Medical Association to acknowledge your efforts. You must not let provinces like Ontario and Alberta obstruct such a fundamental step to reforming health care in this country."

"Canadians have been disappointed with the lack of progress since last November. Particularly disheartening has been the passing of the May 5th deadline without the creation of the promised Health Council," added Dr. Gordon Guyatt.

Pellizzari urged the minister not to be deterred in making Commissioner Romanow's report a blueprint for the way ahead by establishing the Health Council now. ♦

Released September 4, 2003

MRG LETTER OF SEPTEMBER 3, 2003 TO HEALTH MINISTER

The Medical Reform Group, physicians and medical students in Ontario with a long history of support and advocacy for Medicare in Canada, wishes to express our appreciation for your recent efforts to establish a Health Council to oversee and implement many of the recommendations made by Commissioner Romanow.

We applaud the strong leadership you are providing to ensure that the health care system in Canada becomes more accountable and effective. Over the past several weeks, you have made your message clear to provincial elected officials that you will establish a Health Council. We join with our colleagues in the Canadian Medical Association to acknowledge your efforts and to wish you success. You must not let provinces like Ontario and Alberta obstruct such a fundamental step to reforming health care in this country for all Canadians.

Canadians have been disappointed with the lack of progress since last November. Particularly disheartening has been the passing of the May 5th deadline without the creation of the promised Health Council. We await with anticipation the outcome of your meetings this week with your provincial counterparts. We hope they will heed your message to "keep the momentum going" by moving ahead to make the Health Council a reality.

We speak as physicians who are deeply concerned about the future of the Canadian health care system, and about the health of Canadians in general. We are grateful for the contributions you and your government can and will make by making Commissioner Romanow's report a blueprint for the way ahead. ♦

CANADA HEALTH COUNCIL PLAN A DISASTER, MUST CHANGE

The Medical Reform Group of Ontario has denounced the proposed structure of the National Health Council.

"While Anne McLellan claims to want an independent Council," said MRG spokesperson Ahmed Bayoumi, "the selection process the governments are proposing will ensure a toothless Council that will be another agent of futility and discord."

In the government proposal, the First Ministers will choose the chair, each of 13 governments will select a representative, and 13 non-government representatives would also be selected by the governments.

"The 13 members representing the governments will serve government interests," said another MRG spokesperson, Dr. Rosana Pellizzari. "Unfortunately, provincial governments have consistently done all they could to avoid being held accountable. Government representatives will ensure that the governments will not suffer political embarrassment as a result of Council activities."

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CANADA EALTH COUNCIL PLAN A DISASTER, MUST CHANGE

“As if this is not bad enough,” added Dr. Bayoumi, “governments will be choosing the experts and public representatives. Governments are unlikely to choose anyone committed to toughness in holding government responsible for fulfilling their commitments.”

Along with the Canadian Health Coalition, the MRG is suggesting an alternative process. Governments should choose an independent nominating committee of eminent Canadians who have demonstrated leadership in establishing and maintaining a national, publicly funded, universally accessible, comprehensive system of health care delivery. The Eminent Persons Committee would receive all nominations and present a slate to first ministers based on the objective of independence, expertise, geographical representation, and guardianship. “We need a watch-dog,” Dr. Pellizzari concluded. “The current process ensures we will get a lap-dog.” ♦

Released September 29, 2003

SECOND LETTER TO HEALTH MINISTER MCLELLAN ON HEALTH COUNCIL SEPTEMBER 29, 2003.

We have previously written to you commending your resolve to establish a Canada Health Council and suggesting nominees for the Council. You have shown courage and determination in the face of provinces vocally threatening to renege on their prior agreement.

We are now writing to express our dismay at the proposed structure of the council. While you appear committed to the council's independence, the suggested composition, and procedures for selection, ensure that it will not be independent.

The Council will be sufficiently large as to be unwieldy, but this is a minor problem in comparison to the issue of independence. The 13 members selected acting as government representatives will serve government interests. Unfortunately, over and over again, provincial governments have behaved as if it is not in their interest to work together with the federal government to optimise health care for Canadians, nor to be held accountable. One can be sure that their representatives will behave in exactly the same way, ensuring that the governments will not suffer political embarrassment as a result of Council activities.

As if this is not bad enough, governments will be choosing the experts and public representatives. This will ensure that those committed to toughness in holding government responsible will, at best, constitute a small minority of the expert and public representative members.

We suggest an alternative process. Governments should choose an independent nominating committee comprising a small number of eminent Canadians who have demonstrated leadership in establishing and maintaining a national, publicly funded, universally accessible, comprehensive system of health care delivery. The Eminent Persons Committee would receive all nominations and present a slate to first ministers based on the objective of independence, expertise, geographical representation, and guardianship.

Minister, if the provinces cannot agree to a truly independent Council, the federal government must proceed unilaterally. A Council with the current nominating process will be of no benefit to Canadians. ♦

CITIZEN ENGAGEMENT

Janet Maher

It's possible members noticed in the list of cabinet appointments for the new Ontario government, that Attorney General Michael Bryant includes in his responsibilities something called 'democratic renewal.' Last week, when the Martin cabinet was announced, there was a similar addition, of 'democratic reform' among the responsibilities of house leader Jacques Saada.

Despite many promises for new program initiatives during their respective campaigns, the leaders at both levels have changed their tunes on

assuming power, with claims about the need to curb spending, to limit expectations and to continue or at least not to depart substantially from the tax-cutting agendas of their predecessors.

In contrast to earlier governments, though, both leaders are continuing to maintain the commitment to consult with constituents on the speed and form with which promises might be kept. There are a number of opportunities which will become available early in the new year, and some of our allies are organizing to take advantage of some of them to advance two main principles for consid-

eration: 1] that spending to improve public infrastructure is an investment in expanding service capacity which is critically needed after a decade or more of cuts and flatline budgeting; and 2] that the user fees introduced to make up for cuts tend to hit the most needy when they are least able to pay.

Both federal and provincial governments expect to expand their prebudget consultations in February and March. To make sure you are informed and able to participate, please watch the Alternative Budget website at www.policyalternatives.ca ♦

WILL THE HEALTH CARE WATCHDOG HAVE TEETH?

In their dealings over health matters, provincial and federal governments have been devious and self-serving. Roy Romanow's landmark report on how to rescue Medicare included a key recommendation to form a National Health Council.

Romanow saw the Council as serving an auditing function, making sure that public money devoted to health care was wisely spent. More than that, Romanow envisaged the Council as a sort of soul of Medicare, a national conscience ensuring that every Canadian maintains access to high quality health care.

But shouldn't governments have that role?

Perhaps they should but, if so, governments have been derelict in their duty. Rather than working together, both federal and provincial governments have excused their health care failings by pinning blame on one another.

In his interim report, Romanow described "the corrosive and unproductive long-distance hollering and finger-pointing that currently passes for debate on how to renew the health care system".

The federal government has behaved badly by making massive cutbacks in funding transfers for health care to the provinces. Provincial misdemeanors have included complaining about inadequate funds while cutting taxes, and violating the Canada Health Act by allowing direct charges to patients for elective surgeries and diagnostic tests.

Some provinces have also misled the public with statements that health care spending is out of control when the truth is that, as a proportion of gross domestic product, spending is no higher than a decade ago. Provinces have also ignored evidence that investor-owned private for-profit companies deliver health care that is lower quality, and more costly than not-for-profit health care delivery.

Romanow saw that when it comes to health care, our governments have proved untrustworthy, and incapable of co-operation. He proposed the Health Council as a way of dealing with political bickering, and with government lies. The public would have a trustworthy guardian of the health care system. If the provinces, or Ottawa, weren't doing their job or telling the truth, the Council would let Canadians know.

Romanow suggested that to be effective, a Health Council must include scientists who know the evidence about how health systems work best, experts in managing health systems, and public representatives.

An effective Health Council will also require independence. And that is where the train may be going off the rails.

In their health accord of February 2003, the federal and provincial governments agreed to create a National Health Council by May, 2003. Then, in September, they agreed to have the Council in place by October 23.

Due to the usual squabbling, the Health Council remains nothing more than a promise. Alberta has been particularly vocal in resisting a council with the authority and resources to play an effective watchdog role.

Indeed, Alberta looked set to kill the deal. Then, in August, a national poll found that 70 per cent of Canadians thought the federal government should ignore provincial concerns and create the Council right away.

That brought Alberta back to the negotiating table and the governments finally have an agreement with specifics about the structure of the Council. Ralph Klein's latest statements suggest he is once again increasingly resistant to a really effective Council. Moreover, the proposed Council structure has major problems.

The suggestion is that the Council will have 27 members, including a Chair, and one appointee from each of the provincial and territorial governments. Direct government appointees will total 13, because Quebec is not participating.

The other 13 members will be, as Romanow suggested, experts and public representatives from outside government. The plan presents a number of difficulties.

First, a 27-member Council is too big. The large size threatens effective function.

Second, and more serious, is the large proportion of government representatives. Governments have avoided the accountability that the Council is seeking to establish. One can expect provincial government representatives to do all they can to avoid embarrassing criticisms of their home provinces.

Third, governments will control the choice of experts and public representatives. As a result, anyone with a record suggesting they will be tough in holding governments responsible is unlikely to find a seat on the Council.

How should the Council be constituted and chosen to ensure its independence? First, there should be fewer government representatives, or preferably none at all. Second, governments should choose a small number of eminent Canadians who have demonstrated leadership in establishing and maintaining a national, publicly funded, universally accessible, comprehensive system of health care delivery. That group would receive all nominations and present to the first ministers a slate restricted to independently minded individuals.

Can a Council intended to critically review governments' actions function effectively if the governments under scrutiny control the Council's membership? The current structure and process of selection of Health Council members suggests, if we ever get a Council at all, it will operate more like a lap-dog than a watchdog. ♦

First published November 12, 2003 as one of Dr. Guyatt's biweekly columns in the Winnipeg Free Press.

ADVOCATING NATIONAL HEALTH COUNCIL TO THE PROVINCES

In addition to our letters to Federal Health Minister Anne McLellan supporting an independent and workable National Health Council the Medical Reform Group has advocated with Health Ministers in every province, including the Hon. George Smitherman, recently appointed Minister of Health and Long Term Care in Ontario [November 3, 2003 with text as below. Just as the Ontario Legislature rose for the winter holidays, Ontario Bill 8 was referred to committee hearings. As part of its proposal to strengthen the provincial commitment to Medicare, Bill 8 calls for a Provincial Health Council.

Congratulations on your electoral success and your appointment as the Minister of Health and Long Term Care. The portfolio is enormous and the challenges substantial. However, like you, we believe that a great deal can be done to ensure equity of access to high quality care for all, and to begin a new way of ensuring high quality health for all. We'll write again in the coming weeks with some recommendations on how we think this can be achieved.

Further to our October 6th letter to your predecessor, we are writing to encourage you to support the establishment of a Canada Health Council whose membership is predominantly by public representatives and academic experts in issues of health care delivery.

We believe Roy Romanow correctly identified that to be credible and effective, a Canada Health Council cannot be dominated by individuals representing either the federal or provincial governments. A council of public representatives and experts will be objective, use the available evidence to guide their recommendations, and hold both federal and provincial politicians to account. We are very concerned that a council dominated by government representatives will simply be another forum for the airing of federal and provincial disagreements and will therefore be altogether ineffectual for the objectives set for it.

We would like to recommend individuals whom we think would do a good job representing expert analysis and individuals who would do a good job representing the public interest. We have asked each of the individuals we are recommending whether they would be willing to serve on the Canada Health Council. All have agreed to do so.

As public representatives we recommend the following individuals: Wendy Armstrong, Colleen Fuller, Ethel Meade, and Kathleen O'Grady. As experts on the delivery of health care in Canada, we recommend the following individuals: Joan Bickford, Alba DiCenso, Robert Evans, John Frank, Doris Grinspun, Brian Hutchison, Nuala Kenny, John Lavis, Steven Lewis, Noralou Roos, Greg Stoddart, and Armine Yalnizyan. The attachment to this letter [*see Issue 127--editor*] presents the contact information for each of these individuals, and a brief summary of their relevant credentials. If we can provide any further information, please let us know.

A strong, independent, and effective Canada Health Council is critical to the future of public health care in our country. ♦

ESSENTIAL DRUGS FOR AFRICA

On September 30, 2003, the Medical Reform Group joined the campaign for essential drugs for Africa by sending the following letter signed by Gordon Guyatt to Minister of Foreign Affairs and International Trade, the Prime Minister, Ministers of Health and Industry and opposition party leaders:

We are writing to express our support for your decision to amend existing patent legislation that would allow Canadian generic drug manufacturers to export life-saving antiretrovirals to countries facing the AIDS pandemic.

More than 30 million people infected with HIV-AIDS in Africa require urgent access to antiretroviral drugs. With the World Trade Organization's recent agreement paving the way, we believe it is imperative that Canada take this opportunity to respond with leadership and relief for the millions affected by this public health crisis.

We hope there will be support for this proposed amendment from all political parties in the legislature. We look forward to sending a strong and clear message, from the Canadian people, to our global community.

As longstanding advocates for high quality health care for all, we believe that you, our elected representatives, can and must play a critical role in ensuring an effective and immediate response to AIDS in the African continent. ♦

STREET NURSE CATHY CROWE HONOURED (continued)

all her years of working among homeless people in Toronto, where the problem had steadily increased, Cathy called for homelessness to be declared a National Disaster on the same scale as floods and earthquakes. Her friends call Cathy a national treasure, a mixture of love and tenacity, in the league of international humanitarian leaders.

Cathy is determined to end the plight of homelessness in Canada. She exhibits a profound respect for the homeless men and women who struggle daily to survive. She is a major player in the '1 per cent Solution' campaign, which makes the point that in the mid-1990s, federal, provincial, territorial and municipal governments spent about one

percent of their budgets on housing. Since then, governments have made substantial cuts. The 1 per cent Solution calls on governments to double their commitments to housing programmes by restoring and renewing housing spending. ♦

For more information, please visit www.tdrc.net

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

Name _____
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 Telephone _____
 Fax _____
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Membership fees:

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Please return to:

Medical Reform Group
 Box 40074

Toronto, ON M6B 4K4

All categories of membership include a subscription to the MRG newsletter **Medical Reform**.

* Physicians in other provinces may become Affiliate members. Non-physicians may become Associates.

If you prefer, you may pay your membership fees and supporting contributions through our monthly payment option by completing the following authorization and **enclosing a 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 first day of each month, beginning _____, 20____. Please credit the payments to the METRO 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.

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STREET NURSE CATHY CROWE HONoured IN AMSTERDAM

Toronto's famous Street Nurse, Cathy Crowe, received an international Human Rights and Nursing award on October 5th 2003 in Amsterdam, Holland. The award was presented by Nursing Ethics and the International Centre for Nursing Ethics (ICNE).

Cathy has gained her reputation on the streets of Toronto by advocating with and treating the injuries of the cities homeless population.

In 2001, she received an Honorary Doctor of Science in Nursing from the University of Victoria in British Columbia. Some of her work was highlighted in the documentary film "Street Nurse", directed by Emmy and Gemini award-winner Shelly Saywell.

In accepting the award, Cathy said, "homelessness is a violation of the most basic human rights – the right to housing. I am so honoured by this international nursing recognition and it will fuel my determination to keep working for the end to homelessness in Canada."

Cathy Crowe is a Nurse Practitioner at Queen West Community Health Centre in downtown Toronto. She has worked in the area of homelessness since 1988.

She prefers to be called a Street Nurse – a term coined about 10 years ago by a homeless man at the corner of Sherbourne and Dundas in downtown Toronto. She points out that at that time there were only 4 or 5 street nurses in Toronto, perhaps even Canada, compared to probably 100 now, from Victoria to Halifax. That in itself makes a powerful statement about the extent of homelessness.

Cathy obtained her diploma in nursing from Toronto General Hospital in 1972, her Bachelor of Applied Arts in Nursing from Ryerson in 1985, and her Masters of Education (Sociology) from the Ontario Institute for Studies in Education in 1992.

Cathy follows the pulse of health issues affecting homeless people and over the years that has included reduced access to health care, overall deteriorating health, the return of tuberculosis, deplorable

shelter conditions, and an escalating death rate. Along with remarkable colleagues, homeless activists and friends she has fostered numerous coalitions and advocacy initiatives.

Most recently she and colleague Beric German co-founded the Toronto Disaster Relief Committee (TDRC) which in 1998 declared homelessness a National Disaster. The disaster campaign is a three level campaign targeting federal, provincial and municipal solutions to the homeless disaster and housing crisis. Its signature 1 per cent slogan refers to the demand that all levels of government commit 1 per cent of their budgets to an affordable housing.

Citation for Cathy Crowe

Cathy Crowe, RN and Street Nurse, said to an 'Inquiry on Homelessness and Health' in Toronto in 1987: "I wash their feet, and it's tragic and wrong that they have to have sore, injured, frostbitten and infected feet. No-one in our rich society should have to suffer such indignity and injustice". In

(continued on page 19)

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Please visit and comment on our web-site at <http://www.hwcen.org/link/mrg>

Please also make a note of our current contact information

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