Medical Reform

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PAYING FOR HEALTH CARE IN CANADA

Commentary by Gordon Guyatt

The Canadian Medical Association, while expressing a commitment to equitable health care, is at the same time blowing the trumpet of unsustainable public funding. The two positions are incompatible and for many in the CMA's leadership, the latter is the stance to which they actually adhere.

The new CMA president, Jeff Turnbull, is a strong advocate of universal, equitable, high quality publicly funded health care. Thus, he shares the MRG's core values.

The CMA's policy initiative in health care, including invitations of briefs to CMA policy-makers, has provided an opportunity for the MRG to make proposals that may bolster Jeff Turnbull's positions as he contends with opposing views within the CMA leadership. Nothing is more crucial in this debate than the funding issue. The MRG steering committee therefore decided to invest very considerable time and effort to produce a well-researched, evidence-based document regarding the funding issue.

A team on which I participated including Ahmed Bayoumi, Irfan Dhalla, Ritika Goel produced the document which we submitted to the CMA. The document reviews the financing of health care in Canada, makes comparisons with other countries, and presents a framework for dealing with the problem. We were happy with the document, and present a summary and excerpts here. The entire document is available on the MRG website at medicalreformgroup.ca or through the office at medicalreform@sympatico.ca. We hope that MRG members will find the discussion enlightening.

1. Executive Summary

One can look at issues of health care funding from the point of view of total health care expenditures and maximal societal benefit or from the perspective of the Canadian government within the current Canadian political culture. Taking the former perspective, Canada spends a lower percentage of its GDP on health care than some European countries, and a lower percentage of its GDP on publicly funded care than most. Canadians place a very high value on health care and its health benefits, and increases in overall national wealth will allow increases in non-health public and private expenditures despite further increases in the proportion of GDP devoted to health care. These considerations suggest that substantial increases in public expenditure for health care are both feasible and sustainable.

Regarding the relative merits of public versus private funding of health care, strong evidence suggests a number of benefits of public funding. These include advantages of equity (a strong value for Canadians endorsed by the Canadian Medical Association); efficiency (including huge administrative savings); cost control of overall expenditures; quality of care and superior health outcomes; and competitive economic advantages. Relative merits of private funding are restricted to issues of autonomy and benefits to selected populations (insurers, entrepreneurial physicians, for-profit health care providers, and the wealthy). These considerations further support the merits of maintaining public funding of physician and hospital services, and expanding

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

Editorial work this issue: Janet Maher

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

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

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

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

EDITORIAL NOTES

Janet Maher

In Ontario, we are likely facing two elections in the next year. Ontario will go to the polls on October 6, 2011. Although the next federal election date could legally be as far in the future as October 15, 2012, most observers expect a federal vote within the next year. That gives two important opportunities to educate the public and ourselves on ways to maintain, enhance and improve health care in Canada. Neither government has much to boast about.

In spite of increasing legislation at both levels to 'enhance' accountability for health care funding, virtually nothing has been done to enforce regulations that have been in place for a generation. Almost every week, we hear about a new trial balloon testing the appetite of government and Canadians for user fees for medically necessary care or queue-jumping; the recent report of the attempt of a clinic in Quebec to avoid the prohibition on a surgeon taking cash for a private surgery by using a third party fitness centre to in effect be the go-between: the patient is offered the option of paying the fitness centre which will then pay the surgeon. Quebec is only the site of the most recent outrage.

You will notice in this issue we have focused on the so-called challenge of sustainability. While we believe the challenge is a serious misreading of the facts, we do understand the concern of the public, and recognize the opportunity for setting the record straight. As Dr. Jeffrey Turnbull, among others, pointed out in his recent acceptance speech at the Canadian Medical Association—2014 marks the renegotiation of the Federal-Provincial-Territorial health accords. We can be sure that there will continue to be pressure particularly from conservative governments across the country to reduce the role of government at whatever cost, and so we need to maintain vigilance.

Ontario has little to boast about. The devolution to the local health integration networks has defused some of the funding debate to local levels—at least for the time being. They continue as well to drag their feet on the implementation of electronic record technology that might begin to provide better data on what is working and what it not. And, to the consternation of increasing numbers of Ontarians who took the Ontario commitment for poverty reduction seriously, they appear to be moving at just the right pace to avoid the social assistance review which all agree will be necessary to the reform of income security which is so sorely needed.

For more information, e-mail medicalreform@sympatico.ca. ♦

public funding in areas such as prescription drugs and home care.

Canadian governments, despite a record of over 15 years in which public expenditure on health care as a percentage of GDP has risen very little, face the challenge of a public eager for universal high quality health care but reluctant to face the tax increases that would ensure this goal.

The evidence, in the context of the current Canadian political environment, suggests the CMA should aggressively promote public and professional education and policy initiatives in the following areas: i) The advisability and sustainability of publicly funded health care, and the desirability of expansion of publicly funded care ii) the efficiency and equity advantages of general tax revenue as a source of public funding, with the possible consideration of eliminating health care subsidies, raising targeted taxes directed at unhealthy behaviors, levying taxes earmarked for health care spending, and creating a single not-for-profit social insurer in each province iii) the efficiencies in Canadian health care that could come from more rational prescribing, more scrupulous use of diagnostic tests, the nation-wide systematic implementation of innovative health care delivery strategies, and initiatives in areas of public health and the social determinants of health.

2. Health Care and the Challenge for Governments

Health care financing remains a contentious topic in all industrialized countries. Concerns arise from three interrelated observations. First, health care spending is increasing over time and doing so at a faster rate than inflation and, in most countries, faster than growth in the gross domestic product (GDP). Second, public spending accounts for a majority of health care spending. Third, non-health-care government spending has generally decreased and many governments have decreased their revenue base through tax cuts.

These conditions leave governments are under pressure to reduce public expenditures on health care. Voters, however, demonstrate very strong support for publicly funded health care; cuts to health care spending are therefore unpopular and politically difficult. An ideal solution would control public health care spending while maintaining health care delivery at current or better standards and improving the health of citizens. Such a solution, however, has proved illusive.

Confronting this challenging situation requires addressing a number of questions. What is Canada currently spending on health care? What is the appropriate amount of money to spend? What is the distribution of spending amongst public and private sources, and how does this compare to other high income countries? How much of health care spending should be publicly financed? What are the causes of increased spending in health care? Can cost pressures be controlled?

Physicians have a unique perspective to offer in such discussions. Clinicians understand the pressures to use new technologies for diagnosis and treatment. Public health physicians appreciate the influence of social determinants of health and the importance of a comprehensive approach that maintains investments in multiple sectors. Health services researchers study issues such as access to care, health economics, and resource allocation. This report aims to integrate these disciplines to develop a comprehensive overview of possible approaches to funding health care in Canada. In particular, we critically examine market-based reforms that continue to be advanced as a solution for health care funding problems.

3. Costs and Cost Reductions - Summary

The greatest drivers of health care costs in the Canadian context are the increased use of health services by the entire population, and the increased expense of many new interventions. Further technological innovations, including new imaging procedures, devices, drugs, genetic testing and individualized medicine, are likely to provide incremental health benefits while further increasing health care spending. We can likely find some more efficient ways to deliver health care and we should actively seek such measures – but we remain skeptical that such measures can significantly decrease spending. Similarly, there are many ethical reasons to invest in social determinants of health, but there is no assurance that such investments will return cost savings.

4. Public Options for Increasing Revenues for Health Care

Polls indicate that Canadians are strongly support the public health care system and have little interest in a more private health care.[1] As the economy recovers, governments should look at smart social investments. Expansion of public health care funding should be widely debated, particularly in the form of a national Pharmacare program suggested by the Romanow Report. We need a

[1] Harris / Decima . Most Say Health Care System Working, No Appetite for Further Privatization. 2009. Available: http://www.harrisdecima.com/sites/default/files/releases/071009E.pdf.

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Mechanism for raising funds	Fairness	Administrative costs	Political feasibility
Increasing personal income taxes	Fair	Low	Low
Elimination of the private health insurance subsidy	Fair	Low	Medium
Earmarked taxes for health care	Depends on specifics	Medium	Medium
Prefunding model using payroll tax deductions	Depends on specifics	Medium	Medium
Earmarked Taxes on sugary foods and beverages	Controversial	Medium	Medium
Social health insurance	Dependent on specifics	High	Medium

national debate about the appropriate rate of public expenditure in Canada. We spend less of our GDP publicly than most comparison countries and have lower taxes.

A variety of public options should be considered in order to accommodate increases in costs for physician and hospital services and raise the funds necessary for Pharmacare, home care, and other extensions of Medicare. Each of the potential sources of revenue should be evaluated in terms of whether it is fair (i.e., an option should be considered to be unfair if the costs are disproportionately borne by those with relatively low incomes), whether its administrative costs will be overly burdensome and whether it is political feasible. Several such options are displayed below in Table 1.

4.1 Increasing income tax rates

Increasing income tax rates as a strategy for funding health care has enormous advantages in terms of both fairness (because taxes are progressive) and administrative efficiency and simplicity. There is, however, currently little or no desire among Canadian politicians to raise income tax rates, even to fund social programs that most Canadians feel are worthwhile.

4.2 Elimination of the private health insurance subsidy

Governments should seriously consider elimination of the private health insurance subsidy. Because the subsidy is proportional to the highest income tax rate paid by an individual, those with the highest incomes benefit the most. Eliminating the subsidy would be associated with minimal or no administrative costs. Even though most economists agree the subsidy is inefficient and unfair, proposals to eliminate it will likely be opposed not only by the insurance industry but also by those with private health insurance and the associations and unions that represent them.

4.3 Taxes directed to health care

Earmarked taxes for health care are appealing because the public generally indicates an increased willingness to pay higher taxes for better health care. Earmarked taxes should be developed thoughtfully however, since they can be highly unfair. For example, the British Columbia Medical Services Plan premiums represents 2.3% of pre-tax income for someone with an income of $30,000 per year but less than 0.1% of income for someone with an income of $700,000 per year. In contrast, a graduated earmarked tax varying between 0.5 and 2.0% of income would likely raise sufficient funds to bring prescription medications within Medicare.

One form of an earmarked tax is prefunding. In such a model, workers would contribute to a fund that would be invested and used to pay for health care in the future. The fund would be collective rather than individual, to ensure risk pooling. Mark Stabile and Jacqueline Greenblatt recently proposed developing such a mechanism to pay for prescription drugs.[2]

Prefunding has several advantages, including transparency and improved intergenerational equity. The Canada Pension Plan provides an example of how prefunding can work for a social program. However, prefunding for health would be challenging to implement. It is also not clear how accurately health care costs in any one sector (e.g., prescription drugs) can be predicted several decades into the future.

4.4 "Sin" taxes

Historically, increasing taxes on activities - particularly smoking and alcohol - that are detrimental to health, has proved politically palatable. For tobacco and alcohol, governments have exhausted this possibility, which in the case of tobacco resulted in a

[2] Stabile M, Greenblatt J. Providing Pharmacare for an Aging Population: Is Prefunding the Solution? ISBN 978-0-88645-217-9 (Online). IRPP; 2010. Available: ISBN 978-0-88645-217-9 (Online).

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lucrative black market. Given current perceptions, however, taxes on sugary foods and beverages, or other goods and services with a negative impact on human health, may be feasible and have not been adequately explored. Although likely to be controversial, in time these taxes may become as accepted as cigarette excise taxes. Whether these taxes are fair or not is a controversial issue; although they are paid for disproportionately by those with lower incomes, the same individuals also benefit from reduced consumption due to higher prices

4.5 Social Insurance

Some see social insurance, which has worked reasonably well in Europe for decades, as a way to raise revenues and potentially to spur competition. Social insurance in Europe has, however, proven more expensive than tax-based funding (the administrative costs of collecting social insurance can be substantial), and lowers overall labor force participation. It is also limited relative to tax revenue in being restricted to formal earnings.[3,4]

Despite these disadvantages, in a political environment in which the population is unimpressed with the equity and efficiency merits of general tax revenue increases, governments might reasonable consider social insurance. Practical barriers may, however, prove formidable. Social insurance in Europe developed over decades, and the non-profit insurers that pay for health care in many European countries do not exist in Canada. The administrative costs and political feasibility of establishing competing non-profit insurers may be prohibitive.

On the other hand, a single social insurer for each province, administered at arm's length, is similar to the model that Alberta is exploring with its development of Alberta Health Services, an agency charged with delivering hospital care and many other health services throughout the province. Provincial governments might reasonably explore the possibility of establishing a single social insurer for their province.

5. Conclusion

The Canadian Medical Association has a unique voice in the debate over health care spending. That voice can also be extremely powerful as a tool for public education. A contentious and emotional debate regarding health care funding is about to emerge. The CMA should be ready with a clear and cogent message. The evidence presented in this submission can provide the basis for that message which should include the following elements.

1. CMA documents in development affirm that access should not be constrained by ability to pay. These documents should be central to CMA public positions. Advocating for a system in which Canadians with higher incomes can purchase seats at the front of the health care plane would violate both the letter and the spirit of the fundamental philosophic positions that the CMA is wisely adopting.

2. Relative to public funding, market-based solutions increase costs, reduce quality, and increase health inequities. In addition to violating the values captured in CMA principles, private funding options represent a bad deal for Canadians.

3. Public rhetoric is overwhelmingly and almost hysterically raising cries regarding out-of-control, unsustainable health care costs. The CMA should point out how misleading such rhetoric is. In comparison with other high income countries Canada has done a remarkably good job of controlling health care expenditures over the last 15 years. Health care advances bring important health benefits that Canadians value highly. Health care spending will not consume the entire benefits of a growing economy and will therefore continue to allow increases in spending on other public and private priorities. European countries manage higher total per capita GDP expenditures on health care greater than Canada's, with higher percentages of expenditure funded by taxes. Keeping physician and hospital services publicly funded, and expanding public funding in areas such as prescription drugs and home care is both feasible and sustainable. If the CMA took on aggressive advocacy of a national Pharmacare program and made it a key objective, it could bring new life to a key initiative that remains stalled.

4. Funding predictable increases in health care expenditures would be done most efficiently and fairly by increasing existing tax rates. In the face of continued government and public resistance to tax increases, governments should eliminate health care subsidies, and explore possibilities of raising targeted taxes directed at unhealthy behaviors, levying taxes earmarked for health care spending, and creating a single not-for-profit social insurer in each province.

5. The CMA should educate Canadians that more health care is not necessarily better. The CMA is ideally positioned to advocate for efficiencies in Canadian health care

[3] Evans RG. The Iron Chancellor and the Fabian. *Healthcare Policy*. 2009;5:16-24.
[4] Wagstaff A. Social health insurance reexamined. *Health Econ*. 2010;19:503-517.

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that could come from more rational prescribing, more scrupulous use of diagnostic tests, the nation-wide systematic implementation of innovative strategies (such as systematic joint replacement systems of care, or community integrated specialty services), and initiatives in areas of public health and the social determinants of health. ♦

EXPANDED SCOPE OF PRACTICE FOR NURSE PRACTITIONERS

On August 23, 2010, Steering Committee member Ritika Goel prepared the following submission to the Health Professions Regulatory Policy and Program Branch of the Ministry of Health and Long Term Care, with a copy to the minister to underline the benefits of expanded scope of practice for Nurse Practitioners

Dear Colleagues,

On behalf of the Medical Reform Group, a voluntary association of physicians and medical students committed to maintaining and enhancing high quality publicly funded health care for all, we would like to thank the health minister for soliciting the opinions of professionals, organizations and community members on this issue of grave importance to our health care system.

Nurse Practitioners (NPs) are exceptionally skilled and highly trained individuals who are required in Ontario to have a four year undergraduate nursing degree and at least two years of work experience in nursing before obtaining a further two years of specialized training giving them the Nurse Practitioner designation.[1] As a physicians' group whose members have experience in diverse practice settings, many of us have first-hand experience working with Nurse Practitioners and can attest to the great knowledge and skills they possess as well as the positive contribution they make to our health care system. In Ontario, we are already successfully using Nurse Practitioners in community health centres, clinics, emergency rooms, long term care facilities, public health units and various inpatient and outpatient hospital settings.[2] The simple extension of their privileges to allow for admission, transfer and discharge of inpatients is without question a positive move to be supported.

We are already on record in support of Bill 179 which has expanded roles of various allied health professionals, specifically allowing Nurse Practitioners not just to prescribe but also to communicate diagnoses, do more procedures, dispense medications and perform and order a wider range of investigations than previously.[3] We applaud the plans of the ministry to expand further the roles of Nurse Practitioners by removing more restrictions on ordering tests and by allowing them to fill out death certificates.[4]

There is evidence to support the roles that Nurse Practitioners are currently performing in Ontario and beyond. The first Nurse Practitioner-led clinic opened in Sudbury in 2007, along with a promise from the current government of 25 more clinics to be operational by 2011. We have since seen the announcement of 11 more clinics, all in underserviced areas and the locations for the remaining 14 clinics should be announced soon.[5] The response to these clinics by the patients they serve has been positive, especially since the clinics serve those in the greatest need such as the 20,000 previously orphaned patients in Belleville[6] and those with mental health concerns in Durham who have often been turned away by other clinics and providers.[7]

The literature evaluating the use of Nurse Practitioners in various settings in health care has been very promising. A systematic review published in the British Medical Journal in 2002 looked at Nurse Practitioners in the primary care setting. A total of 34 studies were compiled to find that quality of care was better for Nurse Practitioner consultations; while there were no differences in prescriptions, return consultations or referrals, patients were more satisfied with care by a Nurse Practitioner.[8]

A recently published article by an internationally recognized medical economist and health futurist uses economic analysis and literature review to make the case that further use of Nurse Practitioners in various levels of the American health care system would lead to tremendous cost savings. This includes situations where Nurse Practitioners are the ones providing inpatient care. We can draw similar conclusions for the Canadian system.[9]

Returning to the issue at hand, currently in Ontario, Nurse Practitioners are permitted to admit, treat and discharge in emergency room settings as well as primary care settings. However, the current legislation does not

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permit admission or discharge of inpatients by Nurse Practitioners unnecessarily clogging the system if there are no physicians available at the time or are unable to perform these procedures in a timely way. The extra cost of keeping patients hospitalized unnecessarily and occupying acute care beds can contribute to longer wait times and higher costs. The director of the Registered Nurses' Association of Ontario, Doris Grinspun, agrees with this sentiment commenting that patients can get unnecessarily held up in the hospital occupying an acute care bed simply due to unavailability of a physician to complete the necessary procedures.[10]

As mentioned in your consultation bulletin, Nurse Practitioners already perform admission, discharge and transfer duties in inpatient settings in various countries around the world. In adopting this role expansion, Ontario would only be moving further towards a sensible use of our limited health human resources. A literature review on this issue looks at the emerging role of Nurse Practitioners in acute care and comes to the conclusion that not only are many countries experimenting with this role, but they are finding many potential benefits to patients, families and the health care systems.[11]

Overall, we wholeheartedly support an expansion of Nurse Practitioner privileges to include admission, discharge and transfer privileges for inpatients and welcome any further expansion the government proposes. ♦

[1] "Primary Health Care Nurse Practitioner: RN (EC) Designation." Nurse Practitioners' Association of Ontario. August 17, 2010. <http://www.npao.org/phcnp.aspx>

[2] "Nurse Practitioners: Frequently Asked Questions." HealthForceOntario. June 2009. August 17, 2010. <http://www.healthforceontario.ca/WhatIsHFO/FAQs/NursePractitioners.aspx>

[3] "Regulated Health Professionals Statute Law Amendment Act, 2009." Ontario Ministry of Health and Long-Term Care. 23 Sep 2009. August 17, 2010 <http://www.health.gov.on.ca/english/public/legislation/regulated/regulated_health_professions.html>

[4] "Consultation on Hospital Inpatient Admit/Discharge by Nurse Practitioners." HealthForceOntario. August 17, 2010. <http://www.health.gov.on.ca/en/news/bulletin/2010/np_input.pdf>

[5] "Nurse Practitioner-Led Clinics." Ministry of Health and Long-Term Care. June 25, 2010. August 17, 2010 <http://www.health.gov.on.ca/transformation/np_clinics/np_mn.html>

[6] Dalby, Paul. "Nurse-led clinics win small town hearts." *Toronto Star*. May 10, 2008. August 17, 2010 <http://www.thestar.com/article/421726>

[7] Boyle, Theresa. "GTA's first nurse-led clinic helping Durham feel better." *Toronto Star*. January 2, 2010. Healthzone.ca August 17, 2010. <http://www.healthzone.ca/health/newsfeatures/healthcaresystem/article/744988--gta-s-first-nurse-led-clinic-is-helping-durham-feel-better>

[8] Horrocks, Sue, Elizabeth Anderson, Chris Salisbury. "Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors." *British Medical Journal* 2002;324:819-823 (6 April)

[9] Howie-Equivel, Jill, Dorrie Fontaine. "The Evolving Role of the Acute Care Nurse Practitioner in Critical Care." *Current Opinion in Critical Care*. December 2006 - Volume 12 - Issue 6 - p 609-613

[10] "Ont. Nurse Practitioners May Easy Hospital Flow." CBC News. Aptil 16, 2010. <http://www.cbc.ca/health/story/2010/04/16/nurse-practitioners-hospital-discharge-mcguinty-ontario.html>

[11] Howie, Jill N., Mitchel Erickson. "Acute Care Nurse Practitioners: Creating and Implementing a Model of Care for an Inpatient General Medical Service." *American Journal of Critical Care*. 2002;11: 448-458

HOW TO HEAL HEALTH DELIVERY

Michael M. Rachlis

On Aug. 10 Ontario Ombudsman Andre Marin said the Hamilton-Niagara local health integration network (LHIN) held clandestine or illegal meetings.

There are rising concerns about the LHINs, Ontario's Local Health Integration Networks. On Aug. 10, Ombudsman André Marin accused at least some of the 14 LHINs of counting board members' golf course and supermarket conversations toward their "community engagement" goals. In the past year several communities, including Niagara and Peterborough, have mobilized to fight planned LHIN reductions of hospital services.

Conservative Leader Tim Hudak has promised to dissolve the LHINs. NDP Leader Andrea Horwath more cautiously has called for a review and a moratorium on hospital restructuring.

At least some of the criticism of the LHINs is legitimate. However, all health systems in all jurisdictions have some regional approaches to planning. Not every town got a TB sanatorium in the 1920s or cobalt bombs for cancer in the 1940s. And the ministry strictly doles out cardiac or neurosurgery units now.

In 1974, Dr. Fraser Mustard's Task Force recommended the creation of district health councils and local ministry operational units. Then-premier Bill Davis only established the district health councils as voluntary planning bodies. Thirteen years later, Dr. John Evans recommended a series of integrated regional models for Ontario to consider. Over the years, premiers David Peterson, Bob Rae, Mike Harris and Ernie Eves punted these ideas. Meanwhile, every other province created regional authorities. Finally in 2006, Premier Dalton McGuinty established the 14 LHINs.

Of course, government policies are mainly driven by politics, not necessarily good evidence. So why bother learning the evidence? Stephen Harper and Tony Clement's cancellation of the long-form census has taken this attitude to new lows. And, partly because of this attitude, there is little rigorous evidence on the performance of the Ontario LHINs and other Canadian regional models.

However, it is safe to say that Ontario's approach to LHINs is unwieldy. In other provinces, regional authorities directly deliver the vast majority of home-care services with their own staff. In Ontario, there are three levels of contracts before the patient gets a bath. The LHINs contract with community care access centres for home-care services. Then the CCACs send out RFPs (request for proposals) and eventually sign contracts with various for-profit and non-profit entities. Then the home-care agency signs contracts with individual workers, most of whom are non-unionized. The Ontario high foreheads cite this "purchaser provider split" as if it were a biblical prohibition. Other provinces cite this approach as proof of Ontario's pride-goeth-before-the-fall exceptionalism.

The other provinces also at least had the political leadership to disestablish most of their hospital boards. The McGuinty government judged that Ontarians would resist a similar step here. However, as a result the LHINs are seen as just another administrative tier. And, partly because other corporate boards remained, the LHINs have very few expert human resources with which to fulfill their immense job descriptions.

Finally, the LHINs legislation doesn't mention public health and there is little coordination between public health and the rest of the health system. The province's H1N1 flu management problems last fall reflected this lack of integration.

Something will happen to the LHINs, probably after the next election. And, every other province has at least tinkered with their regional models.

Here's some advice to the government as it reviews the LHINs and the governance of Ontario's health-care system: Start with form following function. Some services, like cardiac care, cancer and emergency services need top-down command and control. Some services, like care of the frail elderly and health promotion, beg for freewheeling bottom-up, democratic, non-profit entrepreneurship.

In B.C., the provincial health services agency coordinates eight specialized agencies, including the B.C. Centre for Disease Control. Cancer Care Ontario plays a similar role for oncology services and could be a model for a provincial health agency in this province.

Ontario's 80 community health centres are governed by elected community boards and typically engage hundreds of their residents every year. And that's not counting chats in line at Tims!

Quebec's 95 local health boards and England's 151 Primary Care Trusts are much closer to their communities than Ontario's 14 LHINs. Ontario should consider

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CANADA PLAYING IN WRONG HEALTH LEAGUE

Michael M. Rachlis

Canadians tend to mock Americans' ignorance of our country and the rest of the world. We do know more about their country than they know about ours. But we also tend to be unsophisticated when it comes to the rest of the world. Canadians need to become a lot more refined if we want medicare to be there for the next generation.

When we compare ourselves internationally, we start and often stop with the United States. Of course, our health system does well when compared with the U.S. But so do almost all other developed countries' health systems. It's like winning a high jump contest against a bunch of midgets. The bar is very low. It means a lot more when we beat the U.S. at hockey.

The U.S.-based Commonwealth Fund released their latest comparison of seven health systems on June 25. Predictably, the U.S. system rated last overall and that was the focus of the fund's report and the U.S. and international coverage. But Canada was second last. We were last for overall quality, effective care and timeliness of access. We scored second last on efficiency.

The report compared Canada with other countries 18 times in the text. These included two favourable comparisons and 16 unfavourable ones, including indictments for long waits, the poor management of chronic conditions (like diabetes), the lack of electronic systems, poor care coordination and the failure to involve patients in decisions about their care.

Other countries, such as the U.K., scored better than Canada while spending a smaller share of their economy on health. And the U.K.'s system is actually more public than ours.

The main determinant of overall health-care system performance is the quality of primary health care. Unfortunately, Canada's system of family doctors and a few community health centres just isn't built to carry the load that it must if Canada is to beat anyone but the U.S. in the health-care Olympics.

The Ontario Health Quality Council has shown that this province's primary health-care services have been getting slightly more effective. The provincial government has established a plethora of new primary health-care models for private doctors. Anecdotally, there is some innovation and many doctors report rejuvenated professional lives. But evaluations indicate that the province has spent a lot of money establishing family health teams in wealthier areas of the province and the new patients enrolled have tended to be relatively healthy.

In the meantime, hundreds of thousands of Ontarians still don't have a primary care provider and the vast majority of current practices in this province still lack integrated health records. As the H1N1 flu problems demonstrated, we need to fully engage primary health care with its natural partner, public health. Ontarians should find it cold comfort to know that primary health care is as bad or worse in other provinces.

Primary health care was identified as a priority by Justice Emmett Hall's national review of medicare in 1980, Dr. John Evans' Ontario-based review in 1987, and dozens of times since. Yet change is still something feared by most providers and many patients as we cling to the mantra that we are better than the U.S.

Paul Martin's 10-year federal-provincial-territorial health accord of 2004 was supposed to heal health care for a generation. But it turned out to be just enough to get the feds back into the health policy arena and give the old system some breathing space.

The Romanow Commission called for federal money to buy change. Unfortunately from my perspective, the calculus of federal-provincial politics ensured that the 2004 accord gave money without strings. It looks even bleaker for those of us favouring a strong federal presence at the table in 2014.

That means it's up to the provinces to take on the heavy lifting of reform. Father of medicare Tommy Douglas always said that medicare would be implemented in

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HOW TO HEAL HEALTH DELIVERY (continued)

establishing democratic control at the local primary health-care level, where most health is delivered.

Finally, regional level governance could be established building on local primary health-care boards.

The LHINs have been a baby step to better integration. Ontario should review its regional model and then reorganize the governance of the health system to balance efficiency, effectiveness and community participation.♦

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CANADA PLAYING IN WRONG HEALTH LEAGUE (continued)

two stages.

The first was public payment for the old system based on treating illness in hospitals. He said the second stage would feature a new system, designed as much as possible to keep people healthy.

He predicted that the second stage would be more difficult to attain than the first and he was right. But we need to move quickly on the second stage or we will risk losing the first. As the Commonwealth Fund study reminds us, we have a long journey ahead of us.♦

Reprinted with permission of Michael Rachlis from the Toronto Star, July 4, 2010

ACCOUNTABILITY ON THE SOCIAL ASSISTANCE REVIEW

The Steering Committee wrote the Premier, along with Minister of Health and Long Term Care, Deb Matthews and Minister of Community and Social Services Madeleine Meilleur on August 20th to press them not to delay in moving forward with a comprehensive income security review in 2010; and to minimize impacts on the health of recipients, to take account in the replacement of the Special Diet Allowance of the concerns of health providers.

We are writing you on behalf of the Medical Reform Group which has worked consistently over the past 30 years to improve the health of all Canadians. As health providers in Ontario, we urge you to implement the recommendations of the Social Assistance Review Advisory Council and carry out a comprehensive income security review, starting in September, 2010.

At the same time we urge you to act quickly to increase the incomes of adults on Ontario Works and the Ontario Disability Support Program. We believe this can be accomplished through a number of options, including tax credits, increased social assistance rates, a housing benefit, tax deductible rent payments or a $100 per month Healthy Food Supplement.

We believe you are aware of the Five Principles proposed by the 25 in 5 Coalition, as guides to improving the lives of low-income Ontarians. We fully support these principles, but feel there are other, health provider-specific, elements that need to be considered if this new program is to grow from the lessons learned from the Special Diet Allowance program.

These suggestions are developed through our experiences as front line health providers working with people who rely on social assistance, and from our experience with the Special Diet program. We hope these principles will help the new program avoid some of the frustrations of the Special Diet program for health providers, and for our patients who live on social assistance.

Our four suggestions are:

1. *Any new program should have clear guidelines as to requirements to qualify for the nutritional allowance*. If a certain level of diagnosis is expected for a medical condition, this should be made clear. This could be expressed as a threshold, a range, or through a case example. This level of clarity will allow health professionals to act as health providers, not gatekeepers, with clear guidelines as to the extent and intent of the program. It is hoped this will allow health providers to feel comfortable they understand the requirements for completing the application for recipients.

Guidelines should be set from an evidence-based standpoint, and should be reviewed after the first six months, then at least annually for the first three years of the program. The review committee should be made up of experts in health and nutrition, with a mandate to consider the program's contribution to the health of people living on social assistance.

2. *The new program should allow some discretion for health providers to add conditions and suggested remuneration amounts, with justification*. From our work with the Special Diet Allowance program, we have learned that no list of conditions can capture all individual nutritional needs. Such a special access process is available in numerous other areas of health care, including access to drug insurance, and access to expensive diagnostic tests. This program should be treated similarly, as a health intervention warranting access based on justifiable individual health needs.

3. *The government should look to its own Special Diet Expert review panel report* for guidance on evidence, conditions, and dollar values. This expert review panel produced a cogent, comprehensive report that detailed an evidence-based approach to determining both included health conditions and appropriate amounts to allow for a

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ACCOUNTABILITY ON THE SOCIAL ASSISTANCE REVIEW (continued)

healthy supplemental diet for individuals with those conditions. Using the panel's findings would provide important legitimacy for this new program within the health community.

4. As has occurred in the latter days of the Special Diet program, especially within Toronto Social Services, *the government should expressly disallow non health professionals to override the professional opinions of health providers*. This practice has resulted in considerable abuse of vulnerable individuals living on social assistance, and in unjust denial of benefits to individuals in high need. It has also angered and alienated health professionals, who find their assessments questioned by non-professional social services workers, based on innuendo and assumption. We find this offensive and contradictory to basic standards of professional integrity.

We look forward to meeting with you to discuss our suggestions and to participate in community consultations around the larger Income Security Review. ♦

WHERE ARE WE ON POVERTY REDUCTION?

When the currently governing Liberals were running for office in Ontario in October of 2007, they made a number of commitments about tackling poverty in Ontario as part of an economic growth strategy. That was just before the reality of the current recession took hold. As a provincial government, the Liberals have taken some incremental steps in a Poverty Reduction Strategy. As we begin to think about the next provincial election in the fall of 2011, it's worth doing a little review.

On December 4th, 2008, about a year after the election, the government announced a strategy and commitments to reduce child and family poverty by 25 per cent by 2013. For the first half of 2009, then Minister of Children and Youth, the Hon. Deb Matthews organized consultations with community groups around the province to test some of the elements of her strategy. A Poverty Reduction Act, passed in May 2009, provided a mechanism for reporting on the progress of the government in meeting its objectives and was accompanied by a target for reducing child poverty by 90,000 children by 2014. To underline the government's good intentions, the 2009 budget accelerated the plan to increase the monthly child benefit for families with children by implementing the 2010 target in 2009.

By December 2nd, 2009, when some of the analysis of the provincial consultations was available, Matthews acknowledged the sorry state of provincial social assistance and appointed a council of 11 acknowledged community leaders to make recommendations by the end of June, 2010 for terms of reference for a social assistance review. Many community activists, aware of the toll a full-blown recession was taking both on the most vulnerable and on families who had never before experienced getting along without a regular pay cheque, called for a similar show of faith in the 2010 budget.

As well, many advocates, including a growing number of health providers and health advocates, called for a general food allowance increase of $100 month to acknowledge the gap between resources available to the average social assistance recipient and the costs of meeting the requirements of the province's mandated Nutritious Food Basket (provincial public health standards requiring each municipality to monitor food access which has been in place more or less in its current form since 1990). Unfortunately, in its 2010 budget, the government pursued a different logic, limiting the increase in the general social assistance allowance to one per cent for most recipients. They also announced the end of the Special Diet Allowance, a social assistance provision that had been in place since the 1960s to allow health providers basically to prescribe additional funds for patients who they believed would benefit from improved access to healthy food. Until 2004, the Special Diet Allowance was little known and little used. But following a campaign spearheaded by the Ontario Coalition against Poverty and supported by many other community activists, the provincial bill for the added allowance increased from an average of $10 million annually through the 1990s to nearly $200 million in 2008. Although that is not a big amount in the context of a provincial ministry of Community and Social Services budget of just under $8 billion for 2008.

The Social Assistance Review Advisory Council was very busy in the first half of 2010. Within weeks of their appointment, as requested, they provided 13 recommendations for short term changes to the social assistance rules that might improve the program for beneficiaries without adding substantial costs. These recommendations, intended to be

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WHERE ARE WE ON POVERTY REDUCTION (continued)

implemented quickly, cost-effective, and consistent with further reform, included amendments to the treatment of assets to allow potential recipients to retain up to $5,000 of tax-registered savings accounts, better treatment of Employment Insurance and earnings to encourage rather than discourage part-time work. Of the 13, 4 were accepted. The effect of these would be to:

- Expand the exemption of small casual gifts as income;
- Shorten the suspension periods for non-compliance with participation (in job search and voluntary activities) requirements;
- Clarify rules for the catch 22 whereby recipients repaying government debts (for example, student loans) from windfalls (for example, long overdue child support) to remove the penalty or disincentive for using assets to pay government debts;
- Amend the shelter allowance calculation for individuals in shared accommodation.

The final report of the Council in May of 2010 sets out and argues for a modest rethinking of the government's approach to social assistance. First by emphasizing that social assistance is but one element of overall income security, the report sets out terms of reference for a Review which would look comprehensively at income security, employment supports and related services for working age adults. Second, given the complicated and piecemeal package that is our current income security 'program', they think it will be essential to take a comprehensive approach, and engage with other levels of government and the private sector on issues including employment standards, employment insurance, public and private pensions and other benefits.

Given the consultative work that has already taken place following the original December 2008 announcement, the Council foresees the review taking place over a maximum of 12 to 18 months. It remains to be seen if the government can see its way clear to beginning that process before the end of their current mandate in October, 2011.♦

CANADIAN HEALTH COALITION CAMPAIGNS

Looking forward to the likelihood of a federal election in the next year, the Canadian Health Coalition has been working with partners to ensure that two important issues are on the national health care agenda.

1. National Pharmacare Strategy

The Coalition has been working since the 2004 Federal-Provincial-Territorial Accord on policy development for a comprehensive national pharmacare plan that would begin to address one of the most significant drivers in health care costs for Canadians (see Spring 2010 Medical Reform for details). The response of government and opposition parties to date has been to focus on the part of the strategy which proposed beginning implementation of the strategy by covering 'catastrophic' drug expenses as the whole strategy.

To counteract this shortsightedness, in 2010, the Coalition Pharamaceuticals Working Group has been moving ahead in policy development on a new "Catastrophic" Drug Transfer, making clear that this is a limited and short term strategy, which could demonstrate the good faith of governments to move on to more comprehensive pharmacare.

The new Catastrophic Drug Transfer should be used to reduce disparities in coverage across the country by covering a portion of the costs of provincial and territorial drug plans. It should also be accompanied by an explicit timetable and plan for reaching the goal of universal public drug coverage. However, it must be accompanied by a set of measures to improve equity of access, value for money, and cost controls:

1. The additional funds in the federal prescription drug transfer must be used to expand access to prescription drugs within provincial and territorial drug plans by reducing deductibles or co-payments or by extending coverage to people who are now not included under their plans. Under no conditions can the funds be used to take away current levels of coverage, especially for seniors.

2. The threshold for eligibility for catastrophic coverage must be low enough to ensure meaningful coverage to a significant number of Canadians in need. We propose the following threshold: No deductible for household income under $33,000. Deductibles will be graduated to 2% for higher incomes. The 2% will also apply on the highest incomes (no cap on higher income earners).

3. Serious measures must also be undertaken to address the rapidly escalating costs of prescription drugs and to address appropriateness, safety and value for money. These mea-

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CANADIAN HEALTH COALITION CAMPAIGNS (continued)

sures include:

- bulk-buying based on purchasing policies that maximize cost reductions
- reference-based pricing. (BC PharmaCare's Reference Drug Program sets a maximum reimbursement price for a group of drugs considered equally effective.)
- public formulary based on a rigorous drug assessment process (using the BC's Therapeutic Initiative as the model for assessing what drugs to pay for).

The Coalition has recently commissioned a study by Carleton University Professor of Public Policy, Dr. Marc-André Gagnon, to review the economic cases of universal pharmacare, and his study should be complete by early September. It is expected that he will argue for universal first-dollar coverage as a more efficient and effective way to provide access, guarantee patient safety, and contain the escalating costs of drugs which cost individuals and governments $25 billion in 2008.

2. Anti-privatization campaign

In collaboration with the Ontario Health Coalition, the CHC has updated its messaging around privatization, noting that the political context has shifted dramatically following the economic crisis of 2009. The current federal government and some provincial/territorial governments favouring the expansion of private health care as a response to the crisis, complain that they have no choice but to reduce funding and/or shift costs from the public to the prate sector.

The coalition strategy focuses on reminding governments about the fact that private care costs more than public health care, and that government has a social responsibility to fund social programs broadly and to maintain and expand health care in particular. ♦

ONTARIO HOSPITAL ASSOCIATION MODEL BY-LAWS WILL MUZZLE CRITICAL DOCTORS SAYS MEDICAL REFORM GROUP

The Ontario Medical Reform Group today called on the Ontario Hospital Association's to withdraw or drastically revise its Prototype Hospital By-laws released earlier this year.

"These by-laws represent a direct attack on the interests of the Ontario public," said MRG spokesperson Dr. Gordon Guyatt. "There are many problems with Ontario hospitals' quality of care. It would be reassuring if Ontario Hospital CEO's were committed to addressing those problems. The proposed by-laws suggest they are not."

The most disturbing aspect of the new by-laws is the specification that duties of physicians will include not to undertake any conduct that would adversely affect the Hospital's reputation or standing in the community. These provisions are a direct attack on physicians' freedom of speech, and on their responsibility to work toward optimal care in the face of perceived problems with care delivery.

"MRG members have witnessed the profound deleterious effect of even less blatantly restrictive hospital by-laws specifying, for instance, an obligation for collegial behaviour," said Dr. Guyatt. Such provisions permit, and have resulted in, coordinated attacks on physicians who perceive problems in care delivery, and have the courage to point out those problems.

"The suggested by-laws, if enacted, will have the effect of creating an atmosphere of fear and intimidation," said another MRG spokesperson, Dr. Ahmed Bayoumi. "They will silence physicians of high integrity considering making sincere and genuine efforts to improve quality of care. These physicians will experience a legitimate fear that any criticism of the hospital will lead to removing their hospital privileges."

"Doctors critical of hospital care may be viewed as troublesome by administrators," Dr. Guyatt concluded, "but they represent a crucial element of checks and balances needed to avoid complacency and defensiveness leading to serious problems in patient care." ♦

Released by the Medical Reform Group August 10, 2010

LETTER TO OHA ON NEW PROTOTYPE HOSPITAL BY-LAWS

Steering Committee member Gordon Guyatt wrote August 10, 2010 to the CEO of the Ontario Hospital Association to oppose their new Prototype Hospital By-laws.

We are writing on behalf of the Medical Reform Group of Ontario, a physician's group dedicated to advancing high quality, publicly funded health care for Ontario residents. We are writing to express our dismay at the Ontario Hospital Association's revised Prototype Hospital By-laws released earlier this year. We are particularly disturbed at specification that new duties of physicians will include not to undertake any conduct that would be disruptive to the Department or affect hospital operations nor any conduct that would adversely affect the Hospital's reputation or standing in the community. These provisions are a direct attack on physicians' freedom of speech, and on their responsibility to work toward optimal care in the face of perceived problems with care delivery.

We have witnessed the profound deleterious effect of even less blatantly restrictive hospital by-laws specifying, for instance, an obligation for collegial behaviour. Such provisions permit, and have resulted in, coordinated attacks on physicians who perceive problems in care delivery, and have the courage to point out those problems. Such attacks have the potential to be motivated by defensiveness, personal hostility, and malice. In a number of instances, these attacks have destroyed physicians' careers.

The suggested by-laws, if enacted, will have the effect of creating an atmosphere of fear and intimidation. They go far beyond previous by-laws that have already been open to sufficiently broad interpretation as to allow successful efforts to remove hospital privileges from physicians of high integrity making sincere and genuine efforts to improve quality of care. Such individuals may be viewed as troublesome by administrators, but they represent a crucial element of checks and balances needed to avoid complacency and defensiveness leading to serious problems in patient care.

We have noted the reactions to your proposed by-laws from the Ontario Medical Association and the Canadian Association of University Teachers. Our group is very different from these. We often perceive the OMA as taking positions that favour doctors' self-interest rather than patients' best interests. The MRG is a doctors' group that was created to defend and advance patients' interests, and has consistently done so. It is unusual for us to find ourselves taking assertive public stances aligned with those of the OMA. We hope that this letter will allow you to see that on this occasion, the OMA's concerns are legitimate, and represent appropriate regard for the best interests of the Ontario public. ♦

A QUICK WAY TO EASE POVERTY

This is excerpted from Toronto Star Editorial of August 17th, 2010 which calls on the province to move quickly.

Urging people to get jobs and then stripping them of the financial benefits that come with work makes little sense. But that is just what Ontario's welfare system does….

Ontario's punitive rule-bound social assistance system not only humiliates and demoralizes recipients, it impedes their transition to the workforce — ultimately costing taxpayers more, not less.

Yet the province has taken so little action that a government-appointed panel of poverty experts went public yesterday with a previously-confidential report — as a way of pressuring the Liberals to speed up rule changes. Most would not cost much money — but could make a dramatic difference to the people mired in red tape.

Social Services Minister Madeline Meilleur had the panel's 13 recommendations before the March provincial budget but implemented only four. She has promised to look at the others as part of a broad review of Ontario's welfare system this fall.

But an expert panel has already assessed the counterproductive effect these rules have. Further study is unnecessary…

The Liberals have made significant strides towards their goal of reducing child poverty by 25 per cent in 5 years. Recently, though, they backtracked by cancelling a program that provided eligible social assistance recipients with extra funds to buy healthy food.

With more than 837,000 people surviving on welfare and disability payments, Ontario cannot afford a system that undermines the very people it is supposed to help. We need a welfare system that harnesses peoples' strengths and reintegrates them into society.

Changing counterproductive welfare rules would be a good start. ♦

AN ECONOMIST AND A PHYSICIAN LOOK AT SUSTAINABILITY

The Canadian Federation of Nurses Unions recently commissioned a comprehensive study, *The Sustainability of Medicare*, from economist Hugh Mackenzie and physician Dr. Michael Rachlis. They provide systematic evidence to refute the idea that medicare costs are out of control and show that the so-called silver tsunami may add up to one per cent annually to health care costs—a far cry from the 'explosion' some would have us anticipate. You can link to it at www.nursesunions.ca/report-study/the-sustainability-medicare.♦

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:

_____

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

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

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

If you prefer, you may pay your membership fees and supporting contributions through our monthly payment option by completing the following authorization and enclosing a 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 Alterna Savings and Credit Union account (No. 1148590) of the Medical Reform Group.
I understand that these electronic payments will continue until I give notice in writing to the Payee to stop doing so; that I must notify the Payee in writing of any changes to the information in the authorization; and that I must notify the Payee within 90 days of any error in the electronic payment.

Account holder's name (print) | Account holder's signature | Date

STUDENTS SEEK TO BETTER EDUCATION ON HEALTH CARE ISSUES

Ritika Goel

Students for Medicare formed on two basic premises. First, we shared a sense of urgency to advocate for a strong, publicly-funded health care system. This led us to hold seminars and conferences to disseminate the extensive evidence supporting a public health care system and to suggest that solutions to our current problems lie within a publicly-funded framework.

Secondly, as students, we felt our respective educational curricula lacked emphasis and rigour on systemic issues. Our newest project is a survey to be posed to students of health professional programs in Ontario to gauge their perceived level of knowledge about Canada's health care system based on their formal teaching.

The areas of knowledge being addressed range from the historical, such as the Canada Health Act, to key distinctions between public and private funding of health care, as well as fine-print issues such as provincially-determined restrictions in service coverage. The survey aims to assess not only the level and quality of the curriculum in our current training systems but also, which specific aspects of our health care system students are most interested in learning about. The survey also aims to incorporate students' suggestions on how their training can be improved.

We also give students an opportunity to tell us about different avenues outside of their formal training that have allowed them to learn about Canada's pressing health care issues. This has been included in the survey because many of our members have gained this knowledge through independent reading, advocacy groups, and community events. We look forward to using the results from this survey to address administrators and students at various schools to draw attention to and possibly help fill whatever gaps in our curriculums that the survey reveals. This ten-question online survey will be disseminated in the fall via students at various schools.

Students for Medicare is a group of health professionals and students, as well as community members and allies, that seeks to promote education and solutions relating to maintaining a publicly-funded health care system in Canada. For more information, feel free to contact us at studentsformedicare@gmail.com or visit our website at studentsformedicare.ca ♦

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]