

MEDICAL REFORM

Newsletter of the Medical Reform Group

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APOCALYPSE NO, THE MYTH OF AGING AND A HEALTH CARE CRISIS

Gordon Guyatt

Everyone knows that the aging of our population will lead to catastrophic demands on our health care system, right?

Wrong.

But our population is aging, isn't it? Yes, it's true that today 13 per cent of Canadians are over 65. By 2031 the proportion will rise to 22 per cent as baby boomers join the elderly population.

Nevertheless, the popular belief that the aging population will lead to a health care crisis is a myth. As it turns out, getting old doesn't, by itself, mean increased use of health resources. What causes increased health utilization is illness. The increasing elderly population is actually getting healthier.

Take my father, for instance. At age 77, he is still playing a vigorous game of squash. My step-mother, at 79, remains extremely active. Doris keeps a full social schedule, and still has the energy to babysit our two very active toddlers. Most important in terms of pressure on the health care system, Doris has no chronic illnesses. Her only medications are prescribed to prevent the heart disease and osteoporosis of which, up to now, she shows no sign.

My parents are typical of the changes in older North Americans over the last 20 years. Disability is strongly associated with health care costs, and residence in a nursing home is a straightforward measure of disability. Of Americans over 65, 5.4 per cent were in

nursing homes in 1985, and 4.6 per cent in 1995, a drop of 15 per cent.

A number of surveys have looked at dependence, the need for help with an activity. Whereas 25 per cent of elderly Americans were dependent in 1984, only 19 per cent were dependent in 1999. This translates in to a decline of almost 2 per cent per year.

Two American surveys have measured functional limitations, such as difficulty walking three blocks, climbing a flight of stairs, or using an object such as a pencil, as well as impairment in hearing and sight. Both surveys show rapid declines in functional impairment from 0.5 per cent to 3.2 per cent per year, depending on the measure and the survey.

Canadian surveys tell the same story. The proportion of Canadians over 75 receiving long-term nursing has

dropped from 16 per cent to 14 per cent since the late 1970s. Over the past decade, life expectancy over 65 has grown by 1.1 years among men with about 70 per cent of that increase without disability. The gain in life without disability in women, 0.8 years, has actually been greater than the gain in total life span of 0.6 years.

The evidence tells us that the elderly are already more healthy. The baby boomers will be even healthier. Major Canadian surveys reveal that the baby-boomer generation suffers from less heart disease, arthritis and limitations than previous generations.

Why is the older population so much healthier? Medical technologies can take some of the credit. For older people with osteoarthritis of the hip or knee, joint replacement represents a medical miracle. The number of joint replacements roughly doubled from the 1980s to the 1990s, allowing many elderly people to stay active. The proportion of persons having cataract surgery doubled as well. My father's cataract surgery helped keep him on the squash court.

Medication is also playing a part. For instance, aggressive treatment of high blood pressure is contributing to the decline in strokes, a very important cause of disability in the elderly. The principle here is very important: new health technologies can actually decrease overall health costs.

Health technologies can't take all the credit. Smoking rates have declined

(continued on page 2)

INSIDE

| | |
|---------------------------------|-------|
| Medicare Refugee Myth | 3 |
| Release..... | 4 |
| Premiers Meet on Health..... | 4-5 |
| Federal Health Ministers | 6-7 |
| Regional Reports | 7, 9 |
| Anticipating Romanow..... | 10-15 |
| International News & Views..... | 16-23 |
| Fall Members' Meeting..... | 24 |

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 <mrg@web.ca>.

Send correspondence to *Medical Reform*, Box 40074, RPO Marlee, Toronto M6B 4K4. Phone: (416) 787-5246; Fax (416) 782-9054; e-mail: <mrg@web.ca>.

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.

APOCALYPSE NO, THE MYTH OF AGING AND A HEALTH CARE CRISIS (continued)

from about 40 per cent in 1960 to 25 per cent today. Smoking is associated with stroke, heart disease, and respiratory disease, all important causes of disability. Non-smoking elderly tend to stay healthier and more active, with less need for medical interventions.

Education is another important factor. Poorer people with less education have higher rates of illness and disability. The share of the elderly with some college education has doubled from the early 1980s to the late 1990s, and this change also contributes to the more healthy elderly population.

The second reason that the popular wisdom about the aging population and exploding health care costs is a myth is that, even aside from the decreasing disability, population aging has a limited impact on use of health services. Despite a higher proportion of elderly, for instance, the number of days Canadians spend in hospital has dropped by two thirds since 1970. Large increases in pharmaceutical costs are almost totally explained by more expensive medicines, with increased use by the elderly responsible for only a trivial part of the total.

In December 2000, the Canadian Institutes for Health Research reviewed the issue of the impact of aging on health care costs and concluded that "expenditure increases resulting from population growth and aging, by themselves, will be stable and relatively modest." Canadian health economist Robert Evans and his colleagues have exposed the aging myth in an article entitled "Apocalypse no: population aging and the future of health care systems." Given the data, the experts' conclusions should come as no surprise.

Unfortunately, the facts will not deter those who use the aging myth as a

way of frightening us into thinking that we cannot afford high quality public health care. Canadian health care is more, not less, affordable than it was a decade ago. The aging of the Canadian population is not going to change that. ♦

(First appeared August 9, 2002 as one of Dr. Gordon Guyatt's twice monthly columns in the Hamilton Spectator and Straight Goods.)

A SMALL BUT IMPORTANT DIFFERENCE

Why does the Globe and Mail persist in confusing the public by referring to private hospitals as something new? (Alberta private hospitals await go-ahead, Globe and Mail, July 12) Over 95 per cent of Canadian hospitals are already private, but are private not-for-profit institutions.

Since recently published evidence has told us that private for-profit hospitals have higher death rates than private not-for-profit hospitals, the distinction is critical. The proposals are not to privatize hospitals, but to turn them over to the profit motive. Perhaps if the issue is clearly presented, Canadians will realize the devastating consequences of such a change. ♦

Letter sent to the Globe and Mail July 12, 2002 by Yves Talbot

CANADIAN “MEDICARE REFUGEE MYTH” DEBUNKED IN MAJOR US STUDY

Charlotte Gray

Canadians are *not* rushing across the border to purchase medical care in the United States, a new study based largely on American data has concluded. In fact, the use of American medical facilities by Canadians is “so small as to be barely detectable.”

The authors of “Phantoms in the snow: Canadians’ use of health care services in the United States” — the article appeared in the May/June issue of *Health Affairs*, the most influential US health policy journal (www.healthaffairs.org/freecontent/v21n3/s6.htm) — conclude that debate over the issue has been driven by politics, not facts. They drew this conclusion from a telephone survey of ambulatory care facilities in heavily populated US urban areas bordering Canada (Buffalo, Detroit and Seattle) and from statewide hospital discharge data from Michigan, New York State and Washington State.

Author Steven Katz of the University of Michigan and his colleagues created a catchy label for the “phantom hordes of Canadian medical refugees” by tagging the notion a “policy zombie” — an idea that is intellectually dead because there is no evidence to substantiate it but somehow manages to live on because it is useful to certain powerful interest groups.

The study, funded by the Canadian Institutes of Health Research, demonstrates that headlines about “medicare refugees” are “a tip without an iceberg.” Of the US ambulatory facilities surveyed, 40 per cent reported seeing no Canadians and a further 40 per cent had seen fewer than 10.

Only 5 per cent of facilities had seen more than 25 Canadians in the previous year, and the most frequent services accessed were diagnostic radiology and ophthalmologic procedures, particularly cataract surgery.

The picture emerging from state hospital discharge data was similar. From 1994 to 1998, 2.3 Canadians were admitted to hospital in the 3 US states studied for every 1000 admissions in the 3 neighbouring Canadian provinces.

Moreover, 80 per cent of the stateside admissions were prompted by emergencies and pregnancies. Of Canadian admissions to US hospitals, only 14 per cent in Michigan, 20 per cent in New York and 17 per cent in Washington State were elective.

Dr. Michael Walker, executive director of the right-leaning Fraser Institute, acknowledges that demand for treatment in US institutions is limited. “We did a survey of US hospitals 10 years ago and heard that Canadians were not a significant percentage of their patient populations.”

Nevertheless, he insists that a Fraser Institute survey of 2700 Canadian physicians’ experiences with waiting lists suggests there has been a modest increase in the number of people looking for treatment in the US. “We asked what percentage of their patients have gone to the US for help. The figure used to be 1 per cent percent, and it has risen to 1.5 per cent. Tiny, but significant.”

Frustration with the current Canadian system fuels misperceptions about better service across the border. Michael Decter, a former deputy minister of health in Ontario, says funding cutbacks during the 1990s meant waiting lists developed for some diagnostic services such as MRI scans and for treatment of specific illnesses.

This led several provinces to sign temporary contracts with US providers to secure specific services, such as cancer treatment. Information about the greater availability of such services in the US was part of every waiting list horror story. But Decter, who now chairs the board

of the Canadian Institute of Health Information, points out that availability doesn’t equal access. “Less than 5 per cent of Canadians feel they are denied access to health care because of cost,” he argues. “The equivalent figure in the US is 24 per cent.”

The medical-migration stories serve some people well, he adds. “Health-system bashing is popular. This myth suits provider groups who want more money and it suits policy-makers interested in floating ideas about privatization.”

Decter says the Katz study raises the interesting economic argument that contracts with US institutions to provide care for Canadian patients can be “a perfectly sensible approach to dealing with patient queues” because they allow service shortages in Canada to be matched to excess capacity in the US.

However, such a practice is largely unacceptable to providers and patients, and this means that politicians who favour or recommend it will likely face a “chorus of accusations that the system fails to meet the medical needs of their constituents.”

“‘If it bleeds, it leads’ is media lore,” Decter concluded. “‘Canadians staying home for health care’ is not a good headline.” ♦

(First appeared as a news item in the Canadian Medical Association Journal, September 3, 2002.)

ONTARIO NEEDS ANOTHER URGENT GOVERNMENT POLICY REVERSAL

The Medical Reform Group today called on the Ontario government to reverse its policy on allowing new MRI and CT centres to charge patients for unnecessary health services.

"The policy makes no sense," said MRG spokesperson Rosana Pellizzari. "Some patients will use the policy as a loophole to jump the queue for access to the tests, and quick results will allow them to jump the queue to obtain quick surgery. For those who really don't need the MRI or CT scans, it makes no sense that they be given priority over those who do."

Another MRG spokesperson, Dr. Ahmed Bayoumi, raised another critical issue. "We have a serious shortage of radiologists and technicians trained in MRI use," said Dr. Bayoumi. "It is completely foolish to waste our scarce resources on patients who don't need the service. In fact, the so-called "yuppie scans" in which patients without symptoms have total body scans, may well do more harm than good."

The MRG joins the chorus of criticism for the government's policy that includes the Ontario Association of Radiologists, whose spokesperson has

labeled the entrepreneurs approaching radiologists to set up private for-profit clinics as "vagabonds, buccaneers and carpetbaggers".

The policy should join the privatization of hydro and the quick increase in nursing home fees in the list of recent reversals of Ontario government policy. ♦

Released August 12, 2002

PREMIERS CALL FOR NEW FUNDING PARTNERSHIP FOR HEALTH CARE FOR CANADIANS

When they met earlier this summer in Halifax, the premiers challenged the federal government to take early action on the Romanow recommendations. Here are the two main communiquees from their meeting of August 1, 2002.

As Premiers, our first priority is improving health services for Canadians wherever they live and regardless of their circumstances.

Today, all Premiers are calling on the federal government to join with provinces and territories in a new funding partnership for health care that meets all Canadians' needs now and in the future. A First Ministers' Conference must be held before the next federal budget to discuss how we can build on the progress made by provinces and territories in a new cooperative relationship that will revitalize and sustain health care for all Canadians.

At the provincial/territorial level, each of us has been working to improve health services for our own citizens through innovations and reforms.

At the inter-provincial/territorial level, following our meeting in Victoria last year, we agreed to lead in restructuring a sustainable health care system. We resolved to work collaboratively on common challenges such as health human resources, pharmaceutical management, continuing care, and other important areas.

We followed up with a special meeting dedicated to health care in Vancouver* in January specifically to advance our common efforts on behalf of Canadians. That progress has been substantial. A common drug approval process is being implemented. Generic drug approvals are being streamlined.

Health care sites of excellence are being identified in areas such as pediatric cardiac surgery, gamma knife neurosurgery, poison drug information services, brain repair and bone and joint surgery. A nursing strategy report will be considered by Health Ministers in September. A multi-faceted home and community care framework for each province/territory to use in improving planning and delivery of services is underway. A coordinated framework to help manage the challenges genetics will increasingly impose for all our health care systems is being developed.

All provinces and territories have indicated their commitment to health care with substantial budget increases that continue to outpace revenue generated

from economic growth. Provincial/territorial health care spending has grown by an average of \$4.25 billion per year over the past five years alone. This amounts to an average increase of more than \$560 for each Canadian.

The fact remains this is simply not sustainable. We need the federal government to assume its fair share of responsibility by joining with us in a new funding partnership that will allow us to make the improvements necessary to sustain health care.

The ability of provinces and territories to meet the health care needs of Canadians is at risk due to the fiscal imbalance existing in Canada. A report by the Conference Board of Canada on Canada's fiscal imbalance released today clearly states: "The federal government's fiscal prospects are in sharp contrast with those for the provincial/territorial governments." It goes on to point out that while federal government surpluses are projected to rise steadily over the next two decades reaching \$85.5 billion, the

(continued on page 5)

PREMIERS CALL FOR NEW FUNDING PARTNERSHIP (continued)

provinces and territories will collectively be in a deficit position throughout the forecast period.

Given the existing and growing federal surplus, Premiers reiterated their call on the Prime Minister to join with them in following through on his commitment to achieve adequate and sustainable fiscal arrangements over the immediate to medium term, including:

- Immediate removal of the Equalization ceiling;
- Immediate work on the development of a strengthened and fairer Equalization program formula, including as one possible alternative, a ten-province standard that recognizes the volatility around resource revenues, and comprehensive revenue coverage;
- Restoration of federal health funding through the CHST to at least 18 per cent and introduction of an appropriate escalator; and

- Work on other measures, including tax point transfers as one possible alternative to the current CHST transfer.

Premiers are asking the federal government to fulfill its constitutional, fiduciary and treaty obligations with respect to Aboriginal people, and actively address disparities in providing health services to Aboriginal people. This fall, the Premiers' Council on Canadian Health Awareness will help inform the public about these facts and challenges and the steps we are taking to address them.

It is important that everyone understands that the failure of the federal government to properly fund this top priority with the tax dollars it receives from Canadians is jeopardizing the long-term sustainability and quality of health care.

All provinces and territories are committed to continue to help financially sustain our health care systems and bring about the innovations and reforms

necessary to improve services for people. As Premiers, we are committed to continuing our work together inter-provincially/territorially to bring about collective improvements in health care services.

When it comes to health care we are doing our share. Now it is time for the federal government to join us in our call for a new health care funding partnership on behalf of all Canadians.

It is critical that we get together as First Ministers before the next federal budget to demonstrate to Canadians our commitment to build this new funding partnership in order to correct the current fiscal imbalance. It is also important that the meeting is structured to allow debate on other matters critical to federal-provincial-territorial interests. ♦

** Quebec will contribute to these initiatives by sharing information and best practices.*

NEW STUDY BY THE CONFERENCE BOARD ON FISCAL IMBALANCE IN CANADA

Provincial and Territorial Premiers today released an independent study conducted by the Conference Board of Canada that confirms the existence of a large and growing fiscal imbalance in Canada between the federal government and the provinces and territories. This study was commissioned by provincial and territorial Ministers of Finance, following their meeting in Corner Brook last April.

Vertical fiscal imbalance is an expression used to describe the situation when the distribution of revenue resources between the federal and provincial/territorial orders of government is inconsistent with the cost of meeting their respective constitutional spending responsibilities.

Based on a projection of federal and provincial/territorial revenues and expenditures over the next 20 years, the Conference Board of Canada concludes that fiscal imbalance "definitely" exists in Canada and is going to "widen in the future". The impact of demographic changes on health care, a program for which provinces and territories are constitutionally responsible, is a major element in this growing fiscal imbalance.

The report prepared by the Conference Board is consistent with the results released recently by Statistics Canada showing that higher social spending by provincial/territorial governments comes at the same time the federal government has been reducing its expenditures.

The study estimates that the federal government surpluses are projected to rise steadily over the next two decades, reaching \$85.5 billion and that the provinces and territories will need to introduce fiscal restraint measures in order to avoid recurrent deficits that could reach as much as \$12.3 billion by 2019-2020. This would permit the federal government to virtually eliminate its interest-bearing debt by 2019-2020, while the aggregate provincial/territorial net debt will increase by 54 per cent to reach \$386.9 billion.

The study entitled "Fiscal Prospects for the Federal and Provincial/Territorial Governments" is available on the web sites of provincial and territorial departments of Finance and on the Conference Board of Canada's web site at www.conferenceboard.ca or by telephoning (613) 526-3090. ♦

CANADA'S HEALTH MINISTERS PROGRESS ON HEALTH CARE RENEWAL AND HEALTHY LIVING

What was said at the federal Health Ministers' meeting September 4-5, 2002 in Banff

At their annual meeting this week, Canada's Health Ministers marked progress and discussed challenges in their mutual efforts to improve publicly funded health care and ensure it continues to meet Canada's needs now and in the future. Two years ago, Canada's First Ministers committed to strengthening and renewing Canada's publicly funded health care through partnership and collaboration.

Federal Minister of Health Anne McLellan and Alberta Health and Wellness Minister Gary Mar co-chaired the meeting, which they described as successful and forward-looking.

Common Drug Review*

In 2001, Health Ministers agreed to pursue a common process for assessing new drugs. Today, Health Ministers announced the establishment of a single, common drug review to be housed at the Canadian Coordinating Office for Health Technology Assessment (CCOHTA). CCOHTA will begin reviews early in the new year. This will streamline the drug assessment and drug plan listing processes.

Accountability

In 2000, First Ministers agreed to build on existing accountability mechanisms through regular, comprehensive and public reporting by each government on the performance of their health system. Health Ministers today announced that each jurisdiction will release its first report by September 30, using jointly agreed upon comparable indicators of health status, health outcomes and quality of health care services. Examples include waiting times for cardiac surgery and radiation therapy for breast and prostate cancer, access to routine health services, and incidence rates for diseases such as tuberculosis and HIV.

Health Human Resources*

Ministers discussed the key role of health providers, including doctors, pharmacists, nurses and other health professionals.

Nursing*

Ministers recognize the important contribution of Canada's nurses. Since 2000, Health Ministers have been taking action on the Nursing Strategy for Canada, a federal-provincial-territorial plan that addresses challenges in the nursing workforce. This strategy continues to be a priority. Among the achievements are better health human resource planning, a 40 per cent increase in spaces nationwide for students in nursing programs, and innovative ways to retain nurses. As well, health ministries are reviewing the recently released report of the Canadian Nursing Advisory Committee, and analysing its recommendations.

Healthy Living*

Beyond considering current needs in health care, Health Ministers also focused on the future.

One key to effective, affordable and responsive health care is to have governments, the health care community, and individual Canadians concentrate on the prevention of illness and the promotion of good health.

To support such an effort, Ministers today agreed to work together on short, medium and long-term, pan-Canadian "healthy living" strategies that emphasize nutrition, physical activity, and healthy weights. The aim is to promote good health and reduce the risk factors associated with diabetes, cancer and cardiovascular and respiratory diseases, and the burden they place on health care. Each year, more than two-thirds of

deaths in Canada result from these four disease groups.

Ministers announced that this winter, a national healthy living symposium will bring together health and other sectors of government, non-government organizations, health specialists, First Nations and Inuit, business and other stakeholders. Participants will set out specific initiatives to support healthy living in the context of healthy communities, including rural, remote and Northern areas. Ministers directed their officials to report on the progress of the new strategy in mid-2003.

Tobacco

Canada's leading cause of preventable death is smoking. After a thorough discussion today of this important health priority, Ministers released a progress report on the national tobacco strategy. It shows the smoking rate has declined to its lowest level since monitoring began in 1965, when the rate was 50 per cent. Ministers also recognized that smoking levels are still very high in certain regions, such as the North. Ministers stressed the importance of continuing action in this area.

Quality Health Services*

Ministers discussed strategies to ensure Canadians have quality health services, with a focus on patient safety. Reducing adverse events is a critical issue for providers, administrators, patients and the public. Ministers are committed to furthering work in this area.

Emergency Preparedness

The tragic events of last September 11 highlighted the importance of the health sector's ability to prepare for and respond to emergencies.

FEDERAL HEALTH MINISTERS (continued)

Continuing efforts include better coordination among federal-provincial-territorial emergency health services, chief medical officers of health, and emergency social services to improve emergency response capacity in Canada.

Future of Health Care

Health Ministers concluded the meeting with a commitment to continue working together on health care renewal. They agreed the upcoming recommendations from the Commission on the Future of Health Care in Canada should recognize achievements to date and build on the progress made by all jurisdictions toward reforming, revitalizing and sustaining Canadian health care.** In anticipation of a First Ministers Meeting, Health Ministers agreed to meet.

"This meeting was focused on taking action now to ensure a sustainable future for Canadian health care," said Gary Mar, Minister of Alberta Health and Wellness. "Over these two days, we developed a much better understanding of our common and unique challenges, and what each jurisdiction can bring to shared solutions."

"This was my first meeting with my provincial and territorial colleagues. I am encouraged by the number of issues dealing with the health of Canadians on which we made progress," said Minister McLellan. "I believe this meeting sets the stage for moving forward quickly and co-operatively post-Romanow as Canadians want us to do." ♦

** Quebec does not participate in these initiatives but contributes by sharing information and best practices.*

*** With the exception of Quebec, which does not subscribe to nor participate in the work of this Commission.*

SHELTER FROM THE STORM

In the *Canadian Nurse*, they wrote: "Shelter from the storm..." If you consider housing a basic health need, then advocacy to end homelessness can be — by extension — part of a committed street nurse's work. This 55-minute cinéma vérité documentary by Michael Connolly about near-epidemic homelessness in Canada is a moving portrait of one group's efforts to make things better..."

The number of homeless people has increased dramatically since the mid-1990s. What can advocates for homeless people do to change anything? In *Shelter From the Storm*, TDRC works with residents of Canada's most famous

squatter encampment Tent City to prevent their eviction. The residents have squatted on unused and polluted land on Toronto's waterfront. The owner of the land Home Depot, the City of Toronto and the provincial Ministry of the Environment want Tent City off. Residents and TDRC push City Council to provide land and new housing.

For more information on the film, or to request a TDRC and/or Tent City speaker for your presentation of the film to your group, contact TDRC at 416-599-8372 or tdrc@tdrc.net. Produced by Brink Inc. in association with the Canadian Broadcasting Corporation. ♦

UPDATE ON COALITION BUILDING IN SASKATOON

Sorry not to have gotten back to you sooner. I was away for the summer and am just working on getting Health Professionals for Medicare up and running again.

Over the summer David Stoll spoke to a few resident's groups. Last week I had a meeting with Dr. Bill Albritton the new Dean of Medicine at the University of Saskatchewan. He is very sympathetic to the cause and pledged his support. We just need to decide what form that support should take.

Yesterday we had our first meeting with students and there were a dozen plus new and eager faces from the first year class. We are now working on educating ourselves about the issues and defining our strategy in regards to gaining access to the professionals and other students.

Last night the local chapter of the Council of Canadians met and Health Professionals for Medicare was part of their discussion. They pledged office space for us and offered to co-sponsor a public event to coincide with the release of the Romanow Report. We will participate in a Sask Health Coalition

provincial meeting in association with the council early next month.

As part of an attempt to increase interdisciplinary cooperation at the student level (and thus at the professional level) we (Med III) share a Community Health and Epidemiology class with the college of physiotherapy.

Today I announced our intentions to bring support for publicly funded, non-profit health care to this class. One of the students came forward and will work on involving Physiotherapy students and speaking to the professional associations. This is the type of connection we're hoping to build to give this initiative wider appeal and influence.

I am currently in the process of approaching students at other schools to encourage similar initiatives. This was discussed at the AGM last year, and raised a great deal of interest.

Once again, sorry for not getting in touch sooner. Please keep sending me information on the activities of MRG. ♦
Ryan Meili

(Late last spring we were contacted by a medical student in Commissioner Romanow's back yard.)

TORONTO DISASTER RELIEF COMMITTEE NEEDS YOUR SUPPORT...

Who Are We and What Do We Do

The Toronto Disaster Relief Committee (TDRC) is a group of social policy, health care and housing experts, academics, business people, community health workers, social workers, AIDS activists, anti-poverty activists, people with homelessness experience, and members of the faith community.

We provide advocacy on housing and homelessness issues. We offer co-ordination services for the National Housing and Homelessness Network. We work closely with Canada's most famous squatter encampment Tent City. We research the issues and have produced numerous reports with our findings. We track the numbers of those who die on our city streets. We watch the homeless disaster worsen daily.

We Believe Homelessness is a Serious Human Rights Violation

The very existence of people who do not have any housing is by itself a most serious human rights violation. The most basic human rights of members of our community are being violated.

We Declare Homelessness a National Disaster

We ask ourselves this — why is this human crisis not treated in the same way as other disasters where people lose their housing and have their family and community networks disrupted, like the ice storm in Quebec and Eastern Ontario, or like the floods in Manitoba?

We Propose Simple Solutions

We call on all levels of government to recognize Homelessness as a National Disaster and to help implement a fully-funded National Housing Program. We propose the One Percent Solution to fund such a program. We ask that all levels of government spend 1 per cent of their overall budgets on housing.

The One Percent Solution would result in \$2 billion in new funding for social housing annually by the federal government, and matched funding shared among the provincial and territorial governments.

We Need Your Support

Homelessness affects us all. Many of us are only two pay cheques or a hardship away from facing eviction. Surely, we cannot rest while there are men, women and children among us who don't even have a place to call home.

What You Can Do

Get on our email list: To keep informed of housing/homelessness issues

Endorse our Declaration: We encourage all people, organizations and levels of government to explicitly recognize Homelessness as a National Disaster and to work together to immediately take appropriate action in all communities throughout the country.

Donate to TDRC: We are a small organization with little funding — in fact

no government funding! To support our organizing efforts please consider making a small donation — whatever you can afford.

Here are just some of our recent involvements...

- Release of Secret Video of Homeless Shelter
- National Housing Week of Action
- Tent City Spring Clean Up Work Party
- Municipal Shelter By-Law support work
- "Open the Armouries!" campaign
- Home-Made Solutions: A One Day Workshop on Creating Housing Quickly
- City budget monitoring — "No cuts to homeless services!"
- "Worst Christmas Ever" report released
- Housing Ministers Meeting in Quebec City--National Housing Framework Agreement signed!!!
- Release of Shelter From the Storm — Documentary on Tent City and TDRC ♦

To become part of the solution-- please support the work of the TDRC

Yes! I/We declare Homelessness a National Disaster!

Yes! I/We would like to support the work of TDRC

Homeless Disaster!

Name: _____

Organization: _____

Address: _____

City: _____ Prov: _____ Postal: _____

Phone: _____ Fax: _____

Email: _____

Please find enclosed a cheque for \$25 \$50 \$100 \$250 Other _____

I/We can't afford to make a financial contribution, but I/we support your work

To donate to TDRC: Please make the cheque payable to the TDRC. If an income tax receipt is necessary please make the cheque payable to "Phoenix Community Works Foundation" and write on the bottom that the donation is for the "Homeless Project". In either case, mail your donation to: TDRC, 6 Trinity Square, Toronto, ON M5G 1B1. Phone: 416-599-TDRC (8372) Fax: 416-599-5445 Email: tdrc@tdrc.net Web: www.tdrc.net

Thank you for your support!



CAMPBELL CUTS THREATEN QUALITY OF CARE IN BRITISH COLUMBIA

On April 10, 2002, a group of physicians in British Columbia took on the Campbell government over its changes to health care in the province, expressing concern at the potential impacts of changes in service and pharmacare coverage on the most vulnerable. Since then they have been consolidating support in the Lower Mainland and the letter which follows is an example of the continuing organizing and consolidation now underway at the Children's and Women's Health Centre. For more information, please contact Dr. Margaret McGregor at (604) 473-1934 or mrgret@telus.net

To: Provincial Health Services Authority Board of Directors
Board of the Children & Women's Hospital of British Columbia

We, the undersigned doctors, nurses and other health care professionals working in programs at Children's and Women's Health Centre, would like to express our concerns regarding the PHSA Board's decision to contract out housekeeping services in some areas of the hospital. In particular we would like to raise the following points:

- 1) Many of us work in programs whose core philosophy is based on the principle of "women-centred" patient care. One of the values of C&W is to "be just and fair with people and act with a social conscience." This means an approach that takes into account the health status of women who face disadvantages in health due to socio-economic status, race, culture, and a range of other circumstances. The decision to contract out housekeeping services to private for-profit companies that will pay their mostly-female employees subsistence wages is likely to create in effect a sub-class of service providers. We feel that this policy toward staff is in direct philosophical contradiction to our approach to the clients we care for and to the values as espoused by C&W and therefore untenable. We believe that all workers in the hospital are part of the health care team, and that one group should not be treated with less respect than another.
- 2) There are increasing reports of poor quality of work provided by private companies whose profit margins depend on lower wages and poorer working conditions. We attach a number of in-depth articles from the United Kingdom addressing this issue. These reports are worrisome in that they suggest the potential for increased spread of infection when housekeeping services are contracted out to low-paid employees excluded from the healthcare team. While we recognize that remaining in the public domain is no guarantee of quality work, jobs that pay at or near the minimum wage are more likely to be associated with increased turnover of staff. High staff turnover and a sense of exclusion from the health care team is likely to result in a lower quality of work. This can ultimately impact on patient care as suggested by the attached references. Indeed, even in the US where contracting out of housekeeping service has been tried extensively, only 15 per cent of hospitals have eventually decided to do adopt this policy.
- 3) The fact that such a major shift in policy has been undertaken without any discussion or debate among those of us providing care to patients is unacceptable given the implications of this decision for our work environment and the potential implications for patient care. We realize that a number of hospitals are looking at the policy of contracting out in response to financial constraints, and we note that CWHBC is the first hospital in Vancouver to actually adopt the policy. We would like instead to see this institution lead a thoughtful discussion and debate about the potential pitfalls of this route.
- 4) There has been no credible and open process established for monitoring the impact of the decision on other staff and on patient care, and no obvious mechanism established for reversing the decision if negative and unintended consequences of the decision are discovered.

Now that the possibility of the contract with A & A has been discontinued, we therefore urge the PHSA Board to undertake a period of open consultation and discussion before any further decision on such a major policy change is made. ♦

Name

Signature

Program/ Area of Work

YUPPIE SCANS WOULD ALLOW QUEUE-JUMPING

How should we decide who gets a medical service quickly, and who waits? Experts generally agree that need for a service should play an important part in the decision. Those in greatest need should have quickest access.

Tony Clement, Ontario's Minister of Health, has come up with a new, imaginative approach to the principle of using need to guide who should receive prompt care. According to Mr. Clement's plan, someone who doesn't need a diagnostic test can get it quickly, while someone who needs it cannot.

This will be the rule in 20 outpatient facilities that will be providing magnetic resonance imaging (MRI) testing and another 5 offering computerized tomography (CT). The procedures are useful for making a variety of diagnoses, but are also expensive. Each MRI machine will cost from \$800,000 to \$2.5 million, each CT scanner up to \$1.2 million. At the moment, only hospitals offer MRI or CT scans, and only to patients who definitely need the tests. In fact, because of the limited number of machines, physicians are careful to use other more available tests if they will provide similar information.

The Ontario Ministry is making plans for another group of people, those who have no medical indication for the high-technology tests. Anyone who is ready to shell out \$700 to \$1,200 for an MRI, or \$650 for a CT scan, will be able to get the procedure. And they can bypass the waiting lists that will remain necessary for those who have a medical indication for the test. But the privileged access will apply only to those who have no need for the test.

If you are confused by this surreal situation, you are not alone. First of all, why would anyone who didn't need an MRI spend \$1,000 to have the test? In the United States, MRI and CT scanning for healthy people is becoming a major industry. People are using the pro-

cedures as a screening test, hoping that it will detect early abnormalities, such as cancer, while they still have the chance for a cure.

Well, maybe. Experience with screening tests has shown they don't always work as expected, and always have substantial down sides. First, there is the dose of radiation equivalent to 20 mammograms with the CT. Even more important, both the MRI and CT will sometimes show questionable abnormalities. This leads to fear and anxiety, and to further testing that is likely to be what doctors call "invasive". That means that the tests involve a tube into the lungs, stomach or bowel, or a needle into an organ such as the liver, kidney or adrenal gland. Aside from being unpleasant, such procedures carry substantial risks. And the final result may well be that there was nothing serious wrong in the first place.

Those are the reasons that the U.S. Food and Drug Administration warns that "yuppie scans", as screening CT and MRI scans are sometimes called, may cause more harm than good. It is why the American College of Radiology, and other professional and scientific organizations, do not recommend such screening. And it is one of the reasons that the Ontario Association of Radiologists is very upset about Clement's plan. The radiologists make a number of compelling points. They note a shortage of radiologists and technicians. When we don't have enough personnel for patients who really need a procedure, they ask, why would we allocate scarce resources to people who don't?

The radiologists, along with many other critics, worry about queue-jumping. My doctor tells me she suspects a serious abnormality in my lung, abdomen, or pelvis. I'm worried, want the test as soon as possible, and have plenty of money to pay for it. What's to stop me from turning up at the clinic, asking for a yuppie scan, forking out \$1,000, and jumping the waiting list? And because the

tests are often needed before surgery, once I've got the results, I can leap ahead on the surgical waiting list.

Even Tony Clement acknowledges that avoiding queue-jumping will be a challenge, and an oversight mechanism will be necessary. Initially, Mr. Clement provided no details, but his latest idea seems to be that a doctor will need to order the test while at the same time specifying that the test is not medically necessary.

How's that? I'm supposed to order an unneeded test for my patient, knowing I'm exposing them to electromagnetic radiation? I'm supposed to ignore the risk of a false positive result in which a possible abnormality ultimately proves, after invasive testing, to be a variant of normal? And if something goes wrong and my patient sues, what is my possible defence? The Ontario Association of Radiologists sees all these problems, and has asked the College of Physicians and Surgeons of Ontario, the regulatory body in charge of protecting the public, to address the issues. Ray Foley, executive director of the radiologists' association, has suggested that the program seems to be built around the needs of businessmen out to make a profit, rather than the general public.

What gives the radiologists that idea? "Our members who do MRI and CT scans are being approached on a daily basis by vagabonds, buccaneers and carpetbaggers who want to set up private clinics," Mr. Foley has been quoted as saying. What has motivated Tony Clement to create this mess? I'll pick up that question in my next column, two weeks from now. ♦

(First appeared August 23, 2002 as one of Dr. Gordon Guyatt's twice monthly columns in the Hamilton Spectator and Straight Goods.)

'YUPPIE' SCAN OPEN DOOR TO US FOR-PROFIT CARE

Patient: "Doctor, I'm so worried, I need to have my MRI test right away."

Radiologist: "I'm sorry, the waiting list is two months. Other patients are just as worried. You will have to wait."

Patient: "But doctor, I have \$1,000 right here to pay for the test. That should entitle me to skip the delay."

Doctor: "No, that's only if you have nothing wrong with you, and don't need the test."

Patient: "But doctor, that's the way it is. There is no good reason for this test, and so you should let me have it right away."

Doctor: "Nice try, but you can't fool me. I have a copy of your chest x-ray report, and it shows a shadow in the lung. You really need the MRI to sort out the problem, and that means you'll just have to wait."

The conversation may sound surreal, but it will be possible at the new magnetic resonance imaging (MRI) or computed tomography (CT) facilities that the Ontario government is funding. In a letter to the *Spectator* in response to my last column, Ontario Health Minister Tony Clement promised there will be no queue-jumping for medically necessary services at the new facilities. Patients without any medical indication, however, can pay for the privilege of an immediate scan.

There is no evidence that people having so-called "yuppie" screening scans will be better off as a result of the test, and they are subjecting themselves to radiation and the risk of further dangerous testing. That is why, in contrast to established screening tests for breast, cervical, or colon cancer, yuppie screening scans are not judged medically necessary.

Patients wanting these unnecessary tests can pay up to jump the queue. What has lead Mr. Clement to suggest this bizarre arrangement? The government faces a problem in access to sophisticated diagnostic tests. The demand for CT, and particularly for MRI, is growing. Waiting lists for non-urgent, so-called "elective" scans

can be months long. So, there is little doubt about the necessity for increasing capacity. The government could have met this goal by increasing the number of scanners in Ontario's private not-for-profit hospitals. In addition, they could have provided resources for Independent Health Facilities, established by 1989 legislation, to run out-patient scanners devoted exclusively to OHIP-covered services.

The Ontario government, however, has taken a philosophical position in favour of increased for-profit provision of health care. Tony Clement has proudly stated that he wishes to encourage innovation from for-profit providers, and will encourage bids to run the new facilities from the United States. American companies, long eager to enter the Canadian market, were already approaching Canadian radiologists days after Mr. Clement's announcement.

Mr. Clement was left with a problem. The fee schedule that his Ministry would offer would be insufficient to allow American - or indeed Canadian - companies to generate the 15 per cent profit margins their investors would expect. To attract for-profit companies, the government had to come up with a way to generate additional funds.

Why not just let the companies charge user fees, on top of what OHIP would contribute? Such user charges would violate the Canada Health Act, federal legislation that requires provinces to make health care equally available to all its citizens. Indeed, user charges would break the Ontario law that was passed in response to the Canada Health Act, legislation that prohibits patient charges for provincially insured services.

Mr. Clement's solution was imaginative. Knowing that yuppie scanning is becoming a major industry in the U.S., and American social trends will soon cross the border, he opened the door to private-pay scanning for services that are not "medically necessary". Aside from the problems Mr. Clement faces trying to persuade critics that he can really avoid queue-jumping

for medically necessary services, the situation highlights the problems of American-style for-profit health care delivery. Picture a not-for-profit provider, committed to delivering provincially insured, necessary care, bidding for one of the new facilities.

If the not-for-profit bidder plans to restrict scans to those that are medically necessary, they will be limited to OHIP funding. In competitive bidding for government contracts to run MRI clinics, for-profit companies who plan to use as much time as possible on the better-paying yuppie scans can easily underbid the not-for-profit competitor. The not-for-profit companies must compromise their commitment to those who need testing the most, or fail in the bidding. Thus, for-profit providers drive the entire system toward a bottom-line approach.

The Ontario government has faced heavy criticism from the Ontario Association of Radiologists, and many other observers, for its plan. Was the government taking political risks just to accommodate for-profit health care providers?

Perhaps. An even more frightening possibility is that user-pay yuppie scans represent the first step toward two-tiered delivery of physician and hospital services. Recall that Ernie Eves, at the beginning of his campaign to succeed Mike Harris, expressed a clear preference for allowing wealthy Canadians to pay for superior health care.

His example: MRI scanning. Reporters asked Eves if he was talking about two-tier medicine that would permit people to pay to bypass waiting lists. "Two-tier, you can call it whatever you want," he replied. Public reaction was extremely negative, and Eves quickly backed off. One can't help but wonder if what Eves said first was what he really meant, and if the current Tory MRI initiative is designed to start us down the road toward American-style, two-tiered health care. ♦

(First appeared September 6, 2002 as one of Dr. Gordon Guyatt's twice monthly columns in the Hamilton Spectator and Straight Goods.)

TOUGH ISSUES FOR ROMANOW COMMISSION

The MRG Steering Committee has been following the release of research and other publications with considerable interest. We present in this issue some of the summaries of commission position papers prepared in anticipation of the commission report later this year.

Medically Necessary Services

The Romanow Commission asks three questions:

- 1) Should 'medically necessary' be more rigorously defined in an amendment to the Canada Health Act?

It seems clear that the arguments against are compelling, that is, that policy-makers have suggested unsuccessful definitions in the past and because technology changes and on-going research enlightens us, we would lose too much energy in constant debate and revision. We may have confidence that needs (medically necessary) can be clearly distinguished from wants ('cosmetic') but it may not be as clear that medical necessity is not synonymous with 'essential' (page 5). We take the latter, in the sense of triage, to mean 'emergency'.

- 2) Should decisions about what is and isn't medically necessary be made by healthcare academics, physicians and nurses, or the public?

It's hard to argue against what seems obvious, that decisions would involve input from all three. When the Ontario government held public hearings in 1991 regarding a short list of proposed 'delistings' the results were far from surprising. There was general consensus that the decisions were reasonable and confirmation of the fact that "very few services were found to be outright unnecessary" (page 7).

The more recent Ontario government's legislative decision to delist most physiotherapy referrals had to be accepted despite significant professional and public protest after the fact. What needs emphasis is the glaring omission of significant categories of care (and cure) that are not 'covered', a reflection of how easy it is to normalize what we're used to. The Commission (page 4) mentions home care and prescription drugs but doesn't include pediatric (or adult) dental care nor does it make any reference to the current dilemma of many family physicians and pediatricians, conflicted about how to advise low-income parents of children in the

vulnerable age groups recommended to have three new costly vaccines (against chicken pox, pneumococcal sepsis, and meningitis).

- 3) I think this question tries to address the political dilemma of the individual (patient or doctor) versus the group.

The following principles are always helpful:

As there is with the 'limited use' ODB (Ontario Drug Benefit) prescription forms, so there must always be a way to allow for exceptions to rules and guidelines. Extra paperwork may fatigue the physician and her staff, but if it's 'necessary', the appeal becomes a labour of care. If, though we may not always be able to cure we can always provide care, then timeliness of service may qualify as 'medically necessary'. If it's true that many treatments are traditional, those that have become the standard of care, even if they've not been studied in a random-controlled trial, should be 'grandfathered'.

"A national process could ensure much better evaluation of health technologies. The system may be paying for many inappropriate treatments" (page 7). Alternative treatments must face the same standards that are set for any new 'orthodox' treatment and only a national process is likely to ensure that research funds are devoted to trials of, for example, non-patented herbal preparations.

On page 8 the Commission writers ask us to consider a broad definition of health: "This could mean paying for things that are not medical treatments at all, such as housing or education". Here then, is some official recognition for the second of our MRG principles: "Health is political and social in nature. Health care workers should ... recognize the social, economic, occupational, and environmental causes of disease, and be directly involved in their eradication." ♦

Mimi Divinsky

Home Care

Home care is a fact of life in Canada. Hundreds of thousands of people across the country are receiving care at home that not long ago would only have been given in institutions. So begins the discussion paper on home care released by the Romanow Commission in May. Despite the fact that home care spending represents only 5 per cent of total government expenditures, according to the paper, the growth in spending in home care has soared, at a rate which was double and now is triple the growth in total health care spending.

Yet, it remains a piecemeal service across the country, with many patients paying out of pocket for drugs, equipment and services that are "free" when provided by hospitals. In addition, 2.8 million Canadians - 12 per cent of the population - reported providing unpaid assistance to relatives with long term health problems in 1996. About 90 per cent of all home care is provided free of charge by unpaid friends and relatives.

A national Home care program was recommended by the National Forum on Health Care. Eighty-four per cent of Canadians surveyed by the Canada Health Monitor in 1998 wanted a national home care program. The discussion paper identifies three possible options: a fully funded program, identified as one of the medically necessary services promised by the Canada Health Act; a separate program with the potential for cost-sharing with patients, either through co-payments and deductibles; or the status quo, with a guarantee that government would pay for those with insufficient means.

The discussion paper asks respondents to rank these three options and a fourth: a separate, mandatory insurance plan. Unpaid work by caregivers is also addressed. In this case, the discussion paper identifies that much of this work is provided by women. It acknowledges that tax breaks benefit the wealthy more than the poor, that cash payments to caregivers

TOUGH ISSUES FOR ROMANOW (continued)

may not help if there are no services to purchase, and communities need more resources for respite care, day programs and professional home care services.

The final section of the discussion paper addresses the funding of "acute" home care. This is the home care which is delivered to patients as an alternative to hospital care, or in the case of earlier discharge. All of the points made in the paper support the expansion of funding: current gaps act as barriers to care, current access is inequitable, current payment is a form of passive privatization of funding, and the current patchwork of services are confusing and unevenly distributed. Three questions ask respondents to express agreement or disagreement with increased government funding and to rank order which services should be covered.

Why the questions? Home care which allows hospitals to discharge patients, or prevents frail elderly from being institutionalized, has been shown to be cost-effective. A national home care program would also address long-standing inequities which allow hospitalized patients to get full medical therapy which ends at the elevator doors. In effect, the lack of home care is a barrier to care, impacting more heavily on Canadians with low incomes or without private insurance. The WHO has criticized the Canadian health care system for its dependence on private funds, particularly out of pocket costs to patients and families.

The only way to address these problems is to bring home care into the Canada Health Act. The major obstacle is unwillingness of the federal government to cost-share Medicare with its provincial counterparts.

Perhaps Canadians have and will respond to these questions in a way which illuminates the way ahead for our elected representatives? Hopefully, this will not have been an exercise in futility. Mr. Romanow would be making a major error if he fails to address the home care problem in Canada. ♦

Rosana Pellizzari

Medicare and Globalization

The Romanow Commission's issue paper on globalization issues, produced by the Canadian Health Services Research Foundation, addresses three separate issues.

What is the possible impact of trade deals on health care delivery in Canada? The two key deals are the North America Free Trade Agreements (NAFTA) and the General Agreement on Trade in Services (GATS). What dangers do these agreements pose?

The document points out that foreign businesses, given the opportunity to own hospitals in one province, may insist on the same opportunities in other provinces. Alberta's Bill 11 provides for-profit companies the opportunity to compete with not-for-profit hospitals. A trade challenge could argue that other provinces must provide those same opportunities.

Recently, GATS negotiations on financial services officially opened our commercial health-insurance market, including private insurance for drugs, to foreign investment. What if Canada decided to institute a national pharmacare program? It is very likely that, if foreign companies controlled the Canadian prescription drug insurance market, they would formally charge the Canadian government with expropriation of their companies, and demand reimbursement. Under trade agreement rules, they are likely to win such a challenge, substantially increasing the cost of a national public drug insurance program.

The document suggests that one way of dealing with the problem would be for Canada to clarify the wording of the trade agreements to ensure we are protected from these sort of challenges by foreign businesses. Arguments in favour of increasing protection include Canadian values that support universal care, the efficiency of our national Medicare system, and the risk that trade liberalization would allow foreign companies to

make a profit from Canadian taxpayers' money. Arguments against include the greater choice provided by foreign companies, Canada's own opportunities to market health care services in other countries, and the economic benefits of a thriving health-care industry.

If Canadians go abroad to receive health services unavailable in Canada, should the Canadian government pay? Excessive waits for health services are common in Canada. The Canadian government has contracted out some care, including radiation treatments for cancer. Individual Canadians may also feel waits are excessive, and go out of the country to deal with their problem. In a recent case, an Ontario appeal board ordered the government to reimburse a patient who had gone to England for cancer surgery.

Arguments for reimbursing patients include consumers' desire to get the health care they need, the possibility that we would save money by getting cheaper care elsewhere, and the pressure that the need to pay for out-of-country care would put on provincial governments to maintain in-province services. One argument against is that aggressiveness, rather than need, may start to determine who gets care. Others include the uncontrolled nature of reimbursement on an individual basis, and the short-term nature of the solution to a basic problem of adequate access to care.

Should Canada negotiate the free flow of health professionals through trade agreements? Currently, Canada can make its own rules about which health professionals, such as doctors or nurses, we take in, and which we don't. Other countries can do the same, and admit or exclude Canadians as they choose. In Canada, it is much easier for an American-trained physician to get a license to practice than physicians from other countries. Should we (and other countries) be allowed to continue such discriminatory

(continued on page 14)

TOUGH ISSUES FOR ROMANOW (continued)

practices? Arguments for liberalizing the movement of health professions include the possibility that this will help us deal with our shortage of doctors and nurses, and that we could save money by avoiding the need to train our own health

workers. In addition, our own health professionals could more easily go abroad for additional training and experience. On the other hand, we could end up with more health professionals than we need, or can afford. The quality of our health

workers could deteriorate. We could also be robbing poorer countries of much-needed health workers that those countries have paid dearly to train. ♦

Gordon Guyatt

Consumer Choice

This paper examines how consumer choice in healthcare could be affected by three different public policy approaches:

1. Increasing consumer control over the publicly funded portion of healthcare spending.

Medical savings accounts are discussed as a potential solution. Individuals or families would get a health savings account. People could use these funds to purchase routine care from a physician, acupuncturists, etc. Unused funds would remain in the account to collect interest and patients would be obliged to set aside some of their funds for catastrophic health events.

Several arguments were presented for these medical savings accounts. The public pays and hence deserves a say in how their health tax dollars are spent be it mainstream or alternative therapies. It is proposed without any referenced research to support the claim that consumers could become more responsible in their use of the healthcare system. Finally they argue that medical savings accounts could encourage younger and healthier people to save their share of public healthcare funds in interest-bearing accounts, society would be better able to cope with the predicted escalation in healthcare costs.

Several arguments against these medical savings accounts were presented. Those with chronic health problems will have less money to spend for all their required care. There would be a need for a huge infusion of cash to pay for all the necessary care and everyone's alter-

native choices as well. Ordinary consumers can't be expected to make sound judgments about whether to use their health funds, especially when they are ill. Expanding upon this point some may be reluctant to get necessary immunizations and seek necessary care because of concern about using up their health funds.

2. Allowing more privately funded healthcare

This section explores the question of whether we should establish a parallel private system as in education, where people continue to support the public system with their taxes, but can opt to purchase an additional level of service with their own money.

Several arguments were presented for such a parallel system. People with more money can buy faster cars, bigger homes and better food, and they should be allowed to buy the care they want. More funding from private sources could enhance healthcare services. Canada is the only OECD country that inhibits the growth of a private parallel system for medically necessary health services.

Several arguments against a parallel system were presented. Because of the need to generate profits private for-profit health care is typically more expensive and hence even consumers able to use private funds could eventually see fewer options. Private insurance may not be available to those with the greatest health needs. In a private market, the commercialization of healthcare can mislead and actually endanger consumers. Many industrialized countries have found that as private healthcare spending increases,

government investments decline, causing an erosion in publicly funded care.

3. Publishing performance ratings for doctors and hospitals

Arguments for include: you can't improve something until you know what's wrong; consumers can look up safety ratings for minivans, why not cardiac surgery; enhanced accountability in our publicly funded system.

Arguments against included the fact that performance indicators don't really increase choice in small areas with one hospital or a limited number of specialists etc. It could lead to some problems as encountered in the US like having some centres avoid the riskiest procedures and patients in order to boost their ratings. Health provider cards may divert attention away from public health, education, poverty, etc.

Unfortunately the presentation for the three different public policy options fails to inform the public about the evidence surrounding the options. Although very Canadian to give fair voice to proponents of these issues this failure of presentation leaves consumers uncertain of what the facts and what are ideological positions. ♦

PJ Devereaux

YOUR MONEY AND/OR YOUR LIFE

D *Death rates higher in for-profit hospitals: study* “Mr. Speaker, at the risk of getting into the game of I’ll show you your study; you show me my study, there are studies going back and forth. There is a lot of evidence both ways.”

The quote is from Ralph Klein, speaking in the Alberta legislature in December, 1999. The premier was responding to evidence about the dangers of his proposed legislation to allow for-profit facilities providing surgery that requires overnight stays - what most people would call private for-profit hospitals.

Klein’s response highlights a problem in using research evidence to guide public policy decisions. Consider the question of whether private for-profit hospitals have higher or lower death rates than private not-for-profit hospitals. Mr. Klein would like to argue on the basis of conventional wisdom that for-profit companies can always do things more efficiently. The opposition would raise the image of greedy companies exploiting the public system. If we have no way of making sense of the available research, we may have to fall back on anecdote, intuition, emotion, and conventional wisdom.

Fortunately, in the last 15 years, the medical research community has developed a solution to the problem. The approach, known as “systematic reviews”, relies on scientific approaches to summarizing a body of research.

A team of health care researchers typically carries out a systematic review. They begin by developing explicit rules to decide what studies to include in their review, and what studies to exclude. These rules allow them to choose only high quality studies.

The researchers then conduct an extremely thorough search for all possible studies. The big danger in choosing studies is the risk of bias. If you are a not-for-profit advocate, for instance, you might be inclined to reject studies that favoured for-profit institutions. To avoid this problem, the most rigorous reviews black out the results and discussion. That way,

the decision to include or exclude the study is based only on its methods, and not on its findings.

Our research group at McMaster recently conducted a systematic review looking at the impact of for-profit versus not-for-profit status on hospital death rates, and published the results in the Canadian Medical Association Journal. Dr. PJ Devereaux, a brilliant young cardiologist and health researcher, led our team in ensuring that we met the highest standards of a systematic review. As a result, our study had no difficulty passing the CMAJ’s strict system of peer review.

After screening over 8,000 potentially eligible studies, we found 15 of sufficiently high quality that addressed our question. In total, these 15 studies, all from the United States, examined 26,000 hospitals and 38 million patients. The result revealed a significant increased mortality in for-profit versus not-for-profit hospitals. The size of the effect means that if we converted all Canadian hospitals to for-profit status, the increased number of deaths would be in the range of deaths from colon cancer, motor vehicle accidents, or suicides.

The results are directly applicable to the Canadian health care debate. The current proposals of Alberta and Ontario governments would avoid violating the Canada Health Act by keeping funding public. That means that the for-profit providers would not be able to charge patients directly, but would have to be content with payment from the provincial Medicare plans. The American studies focussed on patients over 65 whose hospital costs are largely covered by US national Medicare, a program that deals with seniors’ health costs. So both the studies in our review, and current Canadian government proposals, look at public funding with private for-profit delivery.

Many people are unaware that our hospitals, though publicly funded, are privately owned and administered. The owners, whether the communities, the hospital boards, religious institutions, or regional health authorities, are all not-for-profit.

Once again, since the Canadian policy debate is over switching from not-for-profit to for-profit hospital ownership, the American studies are directly relevant to the Canadian situation.

When one considers the challenges that for-profit providers face, the results of our study should come as no surprise. Health-care investors expect returns of 10 to 15 per cent or more on their investment. To just break even in comparison to not-for-profit delivery, that means that for-profit companies must cut costs by 10 to 15 per cent. The American studies found that for-profit hospitals employed fewer skilled workers, such as nurses and pharmacists, than did not-for-profit hospitals. In addition, the skill levels, and thus the payment, was lower in the for-profit institutions. The results suggest that differences in levels of skilled personnel is one important explanation for the different death rates.

To deliver a profit to their investors, Canadian for-profit providers will have to reduce costs in a health care environment that has already been severely squeezed with budget cuts. Canadian not-for-profit hospitals have gone through years of cutting beds, firing administrators and nurses, and relying on lower paid nursing assistants instead of nurses. As our research has shown, when there is no fat to trim, for-profit hospitals secure their profits by cutting to the bone. The result is poorer care, and higher death rates.

The CMAJ, along with our study, published an editorial by David Naylor, the Dean of the University of Toronto medical school. In his editorial, entitled “Your Money and/or Your Life, Dr. Naylor’s conclusion is clear. “Does anyone still want to contract out large segments of our publicly financed health care system to for-profit US hospital chains after reading this article? I hope not.” ♦

(First appeared July 12, 2002 as one of Dr. Gordon Guyatt’s twice monthly columns in the Hamilton Spectator and Straight Goods.)

DEVELOPING HEALTHY PRESCRIBING HABITS IN YOUNG DOCTORS

Canadian doctors sometimes prescribe unnecessary drugs, and often prescribe drugs that are more expensive than required. How can we address this problem?

First, doctors don't deserve all the blame. Canadian physicians face a barrage of advertising from the pharmaceutical industry. The industry spends an average of about \$15,000 per year per doctor on promotional activity. The pitch includes personal visits from industry representatives, glossy ads, and gifts that range from pizza lunches to free trips for educational events at luxurious resorts.

Much of the information physicians receive from the industry is misleading. Numerous studies have examined pharmaceutical advertising and found bias. For instance, one study asked expert reviewers to evaluate 109 ads in 10 medical journals. They concluded that 44 per cent of the ads would lead to inappropriate prescribing. Before getting angry about the industry's behaviour, we should remember that the company marketing departments are just doing their job. Marketing responsibility is to sell the product. Industry management is not responsible to the public but to the company shareholders.

Given the industry incentives, it is no surprise that attempts to regulate drug advertising have had limited effect. Imaginative marketing departments will always be pushing the boundaries.

So, is there any solution?

One possibility is to train young doctors to look to non-industry sources for prescribing guidance. Doctors can now access continuously updated electronic textbooks and computer programs specifically devoted to helping them with optimal prescribing. These information sources provide physicians with the latest findings from research studies, and with expert guidance.

Nowadays, excuses for using drug companies as a source of information are wearing thin.

Ten years ago, this logic guided a new policy restricting pharmaceutical marketing activity, including gift-giving, in McMaster University's internal medicine residency program. As director of the program that trains young doctors to be specialists in internal medicine, I participated in the development of the policy. In addition to our concerns about biased information influencing physician prescribing, several McMaster faculty saw ethical problems with physicians accepting gifts from the industry. First, we noted the conflict of interest physicians face when they accept gifts from a company, and then make decisions about prescribing that company's products. Second, we were concerned that it is the public who, without being consulted, ultimately pays for these gifts.

The McMaster policy barred pharmaceutical industry representatives from attending residency program educational events, and ended widespread "drug lunches" in which companies provided catered meals for doctors in training, often along with presentations or videos promoting their products. Finally, we refused funding from industry unless it was "hands off," leaving us free to make our own decisions about educational events for the junior physicians.

Our policy generated considerable controversy. An industry representative threatened a number of faculty members with withdrawal of pharmaceutical company support for both education and research at McMaster.

When the Canadian Medical Association Journal published an account of these threats, the story made national news. A leading industry spokesperson provided a rebuttal in the CMAJ. Some McMaster faculty, fearing withdrawal of

industry support, disagreed strongly with limiting company's access to residents.

What wasn't known until recently was whether the policy had any effect on residents' attitudes after they left the program. Then, last October, an important study from the University of Toronto appeared in the prestigious Journal of the American Medical Association, JAMA.

Investigators from the University of Toronto reasoned that they could determine the effect of the restrictive policy by studying McMaster residents who had graduated from the program after the policy had been implemented. The researchers compared these residents both to McMaster residents who graduated before the restrictive policy was in place, and to Toronto graduates.

In Toronto, industry representatives were allowed to sponsor educational lunches for internal medicine residents, and residents often attended out-of-hospital education and social events, and accepted industry gifts.

The results showed a clear impact of the McMaster policy on resident attitudes and behaviour after graduation. For instance, about 65 per cent of the McMaster residents exposed to the policy found information from pharmaceutical company representatives rarely or never helpful. This was true of less than 40 per cent of the Toronto graduates, most of whom found industry information sometimes, often, or always helpful. Residents who graduated from McMaster while the policy was in place also reported less contact with the industry than either McMaster graduates from before the program, or the Toronto graduates.

Given the strong criticism they had received, McMaster faculty who supported the policy were pleased to find it had made a long-term impact. However, our pleasure was tempered by

DEVELOPING HEALTHY PRESCRIBING HABITS (continued)

the fact that few Canadian residency programs have adopted and effectively enforced a restrictive policy of industry access and gift-giving to residents. Furthermore, we observed the irony of the results, which industry marketing personnel must have noted.

The message for them is clear. Targeting trainees is good marketing, and will affect their long-term attitudes.

Pharmaceutical industry influence on trainees and practising physicians remains enormous. This influence is not all bad. Several times each year, the industry produces a drug that represents an important therapeutic advance. When that happens, company marketing undoubtedly increases the rate of uptake. However, far more often, marketing effectively increases use of expensive prod-

ucts with marginal, if any therapeutic gains over less expensive drugs. As a result, restrictive policies that lead doctors to greater skepticism about industry claims, and greater use of academic sources of information, are surely good medicine. ♦

(First appeared July 26, 2002 as one of Dr. Gordon Guyatt's twice monthly columns in the Hamilton Spectator and Straight Goods.)

MARY ROBINSON: A WOMAN OF COURAGE

The outgoing United Nations High Commissioner for Human Rights spoke in late July with journalist Ian Williams about running afoul of the Bush administration over Israel and the Palestinians, ending the "cycle of impunity" and standing up to bullies.

On Tuesday, the United Nations General Assembly approved Secretary-General Kofi Annan's nomination of Brazilian Sergio Vieira de Mello to become the next U.N. high commissioner for human rights. His term — Vieira de Mello is just the third individual to hold the position — will begin on Sept. 12 and he's sure to be watched closely — by both human rights groups and the Bush administration...

As Vieira de Mello himself told Reuters, "The job in itself is a minefield ... It is the risk of politicization and how to manage that, how to ensure that human rights are not over politicized." And no one can vouch for his assertion better than Mary Robinson, the outgoing high commissioner, whose term ends on the now iconic date of Sept. 11.

It's common knowledge that her defense of the Durban Conference against Racism, which U.S. and Israeli representatives walked out of, her views on the Israel-Palestine conflict and her condemnation of the U.S. treatment of prisoners in Camp X-ray at Cuba's Guantanamo Bay provoked the Bush administration to oppose the extension of her term.

Robinson became the second United Nations high commissioner for human rights in June 1997 after resigning as president of Ireland. Before Robinson,

Ireland's presidency was a ceremonial office, whose holder was expected to do little more than shake hands with VIPs and open schools and hospitals. But when Robinson — a woman with socialist and feminist leanings — was elected, it symbolized the changes in what had been a traditionally conservative and religion-dominated country. She stretched the boundaries of the presidency to fit her concerns, one of the most prominent of which was human rights. She made trips to places like Somalia and Rwanda, and in the Great Lakes region of Africa she coined the memorable phrase, "the cycle of impunity," to describe the process by which leaving mass murder unpunished encouraged others to do the same.

Her name had actually been raised as a replacement for Boutros Boutros Ghali at the head of the U.N., but although she was the right gender, Ireland was not in Africa, and that was where the consensus said that the next secretary general should come from. And when he did, Kofi Annan tapped her for the human rights job. As high commissioner for human rights, she brought a sense of urgency to the position, and the authority of a recently retired head of state. It irked the type of U.N. bureaucrats who would much rather file reports of massacres at the bottom of a cabinet than upset governments. For her, human rights transcended

national affiliations. For example, just because China was big, or Israel had friends in Washington, was no reason to stay silent.

The word went around in the corridors of power in Washington and New York's U.N. headquarters. She was "difficult to work with." Just because the U.S. and Israel walked out of the Durban Conference, she saw no reason to close it down when the rest of the world stayed. She was forthright about abuses of human rights by both Israel and the Palestinian Authority: In Washington she was damned. However, though she leaves the U.N. in a matter of weeks, Robinson refuses to limp like a lame duck. Recently, she was in New York to report to the Security Council on the massacres and the human rights situation in the Congo and was as forthright as ever before giving up what she calls "the day job."

Putting it politely, from the outside it looks as if the Middle East issue was the one that led to, shall we say, diminished enthusiasm for your renewal in office. Is that a fair assessment?

Indeed. It's ironic in a way, because the issue I'm most committed to is the integrity of the human rights agenda, and shaping it so it's not politicized. I applied that faithfully to addressing the problems both in the occupied Palestinian Territory and in Israel, and I have mentally, emo-

(continued on page 18)

MARY ROBINSON (continued)

tionally and intellectually tried to be bound by it. I may have made some mistakes but that is where I'm at, because that is essentially the core of why I took this job.

It was very interesting to me that it is not so perceived on the Israeli side. It may be because I've been over-appreciated on the Palestinian side. But I have condemned unequivocally suicide bombing, and reiterated the need for human security in Israel for political debate.

Even then, in 2000, it was very evident that the occupation is at the root of many of the human rights problems, and the intifada, which had started then, was only at the stage of stone throwing and young people being killed. Since then we have drive-by shootings and suicide bombing which is of course appalling and cannot be condemned strongly enough, certainly not justified by any cause — but the Israeli responses are also excessive.

It worries me that in this great country [the U.S.] that's not the perception: They don't see the suffering of the Palestinian people; they don't see the impact of collective punishment. They do immediately see and empathize — and rightly — with the suffering of Israeli civilians who are killed, or injured, or just frightened, and of course I do too. But I find it very disheartening that there is not more understanding here of the appalling suffering of the Palestinian population, nor appreciation that this is not going to lead to a secure future. It's going to lead to greater hatred and desperation, of further suicide bombings.

You believe your views on this issue were the reason why the U.S. so vigorously opposed an extension of your term?

Yes, combined with the Durban conference. I urged and begged the U.S. and Israel to stay. I told them that all the draft language, which was unacceptable, would be taken out — and it was. But once they left, there are those who refuse now to accept that any good came out of Durban.

I'm not defensive about my record on the Middle East or the Durban conference. I think we achieved an extraordinary breakthrough in Durban against all the odds.

But there are two very different perceptions. I was in Mexico last week for the first of the follow up regional conferences from Durban, and it was a joy to see how much it means for countries in Central and Southern American, Mexico, the host, Brazil, Chile, the way it has brought new hope for indigenous peoples, for people of African descent, for black Brazilians. I was hearing the plans for action to follow up on Durban from civil society and government — and I thought, "At last! The true agenda is resurfacing." Of course, we need it more than ever following the Sept. 11 attacks.

Now, after five years as high commissioner, do you think you have made a difference?

Certainly there's been a change ... I [recently] addressed the Security Council on the Democratic Republic of the Congo and they will publish my report as a document. Five years ago, the S.C. would not have listened to a high commissioner!

There's also been a dramatic shift, and one that I do take some credit for, in the developing world's attitude. When I started back in September of 1997, I was quite taken aback by how many leaders of developing countries told me: "Don't you know human rights is just a Western stick to beat us with? It is politicized, nothing to do with real concern about human rights."

You know, there was an element of truth in that, and so I found it necessary to find, first of all, the true agenda of human rights at the international level. That is to be strong in civil liberties, in the protection and promotion of civil and political rights, and strong in the protection and promotion of economic, social and cultural rights, and to fulfill the express vision and mandate of the establishment of the high commissioner's office, which was to seek consensus on the right to de-

velopment. That's an individual and a collective right, the right of the people to gain the full flower of their human rights.

And that led to more linkage being made by leaders of developing countries between human rights and economic and social development. They began to realize that if you got your human rights right, you accelerated human development, economic development ... What is very clear is that human rights need protection at national and local level, and therefore unless there is more attention to strengthening human rights, and law and administration of justice at national level, then we are not really going to make great progress.

It's reflected very dramatically in the New Economic Partnership for African Development, the NEPAD. The text of that is an extraordinary indication of how far human rights have moved to become the priority tool of developing countries in making progress.

They identified the four priority areas: to strengthen the administration of justice, the rule of law, tackling corruption, and adhering fully to international human rights norms and standards ... To me it is a moral as well as a practical issue. If countries give priority to these issues and cannot find the resources domestically — then that's certainly an area I'm going to address by trying to build quiet alliances for it for when I quit the day job.

Do you have a new day job lined up?

I do feel energized at the end of this quite demanding job, so I have a real sense of wanting to bring this experience into a different and broader field. I have specific ideas for what I want to achieve, but I need to work out practical ways to do it. I'm very interested in the whole debate on shaping globalization and I think that the international human rights norms and standards have a contribution to make to a more ethical globalization.

MARY ROBINSON (continued)

We have the international norms and standards, we have the treaty bodies working more effectively, we have the rapporteurs, there's an ability to name and shame, it's accepted that human rights don't stop at borders — that if there are violations in a country, the international community is rightly interested. The crucial issue now in human rights is national capacity building.

Your concerns have not always been shared by some international organizations: the World Bank and IMF traditionally never let a few prison camps interfere with their appreciation of a good GDP growth rate. Have you turned them round yet?

Certainly, our office is working, particularly with the World Bank but also the IMF and WTO, and we're engaged in a very significant analysis of poverty reduction strategies and we're developing human rights guidelines for them, with close involvement of the W.B., the IMF, and the WTO. This would not have happened two years ago. It's a really interesting intellectual development. Human rights lawyers are listening to economists and vice versa in seeing how the human rights norms and standards can be a positive framework for addressing poverty, because they address participation; it gives civil society tools to measure whether there is progressive implementation of the right to education, right to health, to food, without discrimination against minorities, indigenous people.

The World Trade Organization especially has been seen as totally heartless and ethics-free by design. Have you really given them a heart transplant?

It's true that trade ministers going into the WTO meetings don't bring with them, as I believe they should, a consciousness of the commitments their governments have made to ratify covenants and conventions. Equally, we don't have a situation that it's in the front of the mind of the IMF. In a country like Argentina, where

there are problems, is there sufficient consciousness to help such a government that has ratified the covenant on economic, cultural and social rights, or the Convention on the Rights of the Child to carry through on that, and to progressively implement these rights, or is the emphasis all on structural adjustment? So we need "joined up" government that brings the human rights commitment into the WTO.

At the moment, many governments all over the world are joining up to throw human rights overboard as part of the struggle against terrorism using Sept. 11 as an excuse. If you think you'd made progress before, don't you see lots of it evaporating?

It's a very serious concern. I was struck last month when we had the annual meeting of the rapporteurs and the coming together of the chairs of the treaty bodies, that all these experts were concerned about the deteriorating situation after Sept. 11.

We all recognize the importance of human security, of coalitions against terrorism, of Security Council Resolution 1473 [calling for joint action against terrorism], but nonetheless the impact on the ground is very worrying for human rights. Governments are using it to clamp down on human rights and freedom of expression — human rights defenders branded as terrorists; the harsh climate for asylum seekers and refugees.

The worrying thing is that secure democracies such as the U.S. are not holding the standards properly. Just look at the treatment of prisoners in Guantanamo Bay, and even more so those who have been arrested under immigration laws with no access to lawyers and no information. Nobody knows exactly what his or her situation is.

You have worked hard to engage China, and you were attacked by some of the Irish press for pandering to the occupiers of Tibet. How successful has your engagement with the Chinese been?

In fact, I was impressed by how far we've been able to come since that first visit [to China] in September 1998. When I go back in August for a workshop on the independence of lawyers and judges, it will be my sixth visit as high commissioner. We've had an intensive series of workshops with them, on reeducation through labor, on the police and human rights, devising a human rights training manual for the police, on human rights education and to insert human rights values in the [school] curriculum on secondary and tertiary levels.

But I have no illusions. None of this means we have changed things overnight. On the other hand, nor does a technical cooperation program mean that I don't speak out on human rights issues. Every time I've been in China, I've been very tough on how they treat the Falun Gong, on their treatment of political dissidents. When I went in November after Sept. 11, I made the point to them that they were using it to be more severe on the Uighur population, branding them as terrorists in a way that had not been done before.

So I take up all these issues: They do say to me now, "We know your habits." But that being said, I'm impressed with the progress we've made. When the Chinese sign a covenant, they do it for Chinese reasons — and they are quite serious about it. So we shouldn't underestimate what can be done. Even some of the federations, like the All China Federation of Women, are becoming more and more independent and more and more concerned with the rights of women.

Also, the last time I was there they were taking courageous stands as women in their own area to bring home that the denial and stigma attached to HIV/AIDS meant that there would be a rampant HIV/AIDS problem.

One phrase you coined that will surely live on is "the cycle of impunity." You used it in Central Africa to describe how each person

(continued on page 20)

MARY ROBINSON: A WOMAN OF COURAGE (continued)

who committed genocide thought they could get away with it because their predecessors had. Has the International Criminal Court put the brake on the cycle, or is it just symbolic?

I really think the ICC is an extraordinary step forward, a very important institution, a way of symbolizing that we are going to end impunity for egregious human rights violations. It may take time, but now there is going to be a permanent court, and you can be brought before it if you haven't been before a national court.

I really regret, first of all, the "unsigning" of the statute by the United States. You know, we deal with the integrity and strength of what we build up in human rights, and part of it is that when we sign and ratify instruments we stand by them. What the U.S. has done is to create uncertainty. Signing is usually an indication that ratification is on the way. Now if other countries are under pressure on human rights instruments they've signed, they may say "Well, the U.S. can unsign a treaty, then so can we."

Secondly, I found the controversy about peacekeepers to be very sad. The political resolution of it has angered the human rights community, but it's more important that we get back to strengthening the court. There have been 76 ratifications. Mexico and others are on the way. There will soon be 100 or more.

One of things about the U.N.'s Human Rights Commission in Geneva is that it certainly contains, shall we say, a statistically significant number of human rights offenders: many of them unlikely to rush to ratify the ICC. Even the worst of enemies, like Iran and Iraq, tend to team up there. It must embarrass your office. Can anything be done about that?

It is true that some countries with poor human rights records do try to get onto the commission, to thwart its protection mission. But I've emphasized that it's vital that there be a strong protection role. I also strongly suggested to the commission with both my opening and closing speech in Geneva that membership should

mean something to members. It should be open to all members because that's the U.N. way, but becoming a member of the Human Rights Commission should mean a commitment to put the country in a better shape in ratifying and implementing instruments.

You were a head of state yourself. Has that made it easier to bust the bureaucracy and get things done with countries?

I think I was always clear that I came into this position to do a job, not try to keep a job. I got very wise advice from a friend of mine when I started — "Mary, remember, if you get too popular in that job, it means that you're not doing a good job." So I didn't actively seek to be unpopular, but I knew that to do the job well and bring out what is really the culture of human rights, you have to stand up to bullies, you've got to be prepared to criticize both developed and developing countries.

When I took issue recently with Australia over their harsh detention policy for asylum seekers, they were outraged — "We're a democratic country, we don't need you here" — as if international standards only applied to developing countries. There is that mentality. Whereas if you believe as I do in the integrity of human rights, then they must be applied without fear or favor. And if that's my legacy, I'm happy about that, that can resonate on, and that's very encouraging for those who work on the coalface of human rights and risk their lives. The most I risked is being criticized in press or parliaments.

Do you think your successor will have the same flexibility and force?

I hope for as smooth a transition as possible, to be as helpful as possible and then to clear the field for my successor, which is very important ... I think there'll be a lot of encouragement from the international human rights community, and from my own office. It took quite a lot of building up, but I now lead a great team of very dedicated people and that's the way they want it. And that's the way

the rapporteurs and the human rights NGOs want it, so there will be a lot of encouragement.

Not long after you took office and I spoke to you, you referred to the "terrible bureaucracy" of the U.N. Have you mellowed?

I wouldn't alter a word of it. There are enormous frustrations with working in the U.N. system, not least that the office of high commissioner does not have control over its own financial position, its own personnel. There are so many bureaucratic ways ... a lot of mini managing, which isn't always well intentioned, but it's crucial to have a strong human rights voice in the U.N. in the office of the commissioner. But even so, one of things I've been very happy with is to see the fruits of this mainstreaming in the wider U.N. system, into the executive committees, into peacekeeping, development, into the work of country teams. They now focus more and more on a rights-based approach to development and poverty reduction.

We have achieved at an initial stage the mandate of mainstreaming, and now it needs to be brought to a deeper stage with the U.N.'s millennium goals for which the office is preparing human rights guidelines. It will be interesting to see if we can make this part of a U.N. that is value-led with a strong human rights input.

From salon.com ♦

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

Dear PNHP members and friends,

We need your help. We have launched a campaign to invite every physician in the U.S. to endorse a proposal for single payer national health insurance, as well as to join Physicians for a National Health Program (optional). We ask your help in circulating the following statement and gathering physician and medical student endorsements.

The proposal was crafted by a distinguished physician panel, and will shortly be introduced in the Congress in legislative form. To follow is the executive summary of the proposal; the full text is available on-line at: www.physiciansproposal.org and www.pnhp.org. We hope to publish the statement in a major medical journal with a list of all the endorsers, as well as to present the list to Congress.

You may endorse the statement on-line at www.physiciansproposal.org. Alternatively, you may e-mail (pnhp@aol.com), fax (312) 782-6007, or mail endorsements to PNHP at 29 E. Madison, Suite 602, Chicago IL 60602. Our deadline is Thanksgiving, so we need to act quickly.

We believe that a majority of physicians now support single payer national health insurance. With your help, we can demonstrate that support to the public and the profession. Thanks in advance for your assistance and all your efforts in this struggle.

Quentin Young, MD, MACP, National Coordinator, Physicians for a National Health Program, 29 E Madison, Suite 602, Chicago, IL 60602; (312) 782-6006; fax (312) 782-6007; pnhp@aol.com; www.pnhp.org; www.physiciansproposal.org

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INTERNATIONAL PEOPLE'S HEALTH COUNCIL

In December 2000, more than 1,500 people representing grassroots organizations, met for 5 days in Bangladesh to confirm their belief that the right to health is a basic human right to which all are entitled. The People's Health Assembly heard testimonies from activists and health care workers. It also produced a ground-breaking document: the People's Charter for Health.

"Health is a social, economic and political issue and above all, a fundamental human right..." the charter begins. Its five fundamental principles include a vision of universal, comprehensive primary health care, a recognition that governments are responsible for its provision, and an assertion that health care must be democratized. The charter goes

on to address the social determinants of health with recommendations specifically targeting globalization and policies of the WTO and the IMF.

Those wishing to endorse the People's Charter for health can find it by going to www.phamovement.org. The charter has been translated into several languages and is being used as a tool for advocacy in many countries. As we approach the 2nd anniversary of its declaration, the International People's Health Council (IPHC), a collective of respected international health activists, continues the work of promoting a vision of health linked to the economic and socio-political realities of this world's people.

Maria Hamlin Zuniga coordinates the work of the IPHC from Managua,

Nicaragua. She will be attending the October 27-30 meeting of the Canadian Society for International Health in Ottawa to give an update on IPHC. Dr Mira Shiva, of the Voluntary Health Association in India, also an IPHC member, will also be in Ottawa for the meetings.

MRG members interested in becoming more involved with IPHC can either e-mail Maria Hamlin Zuniga at iphc@cable.net.ni or e-mail me at rosana.pellizzari@utoronto.ca for more information. Even better, plan to join us in October in Ottawa where we will have a chance to meet. ♦

Rosana Pellizzari

CANADA STRENGTHENS ITS RESPONSE TO THE RICH-POOR GAP IN GLOBAL HEALTH RESEARCH

Vic Neufeld

In 1990, an independent international Commission on Health Research for Development (CHRD) submitted the results of a 2-year study on the state of health research in low and middle income countries. Among other important findings, the CHRD reported the startling finding that less than 5 percent of the total global investment in health was targeted on the health problems in low and middle income countries, whose citizens bore 93 per cent of the global burden of illness. Several specific recommendations (including proposed investments) were made to the international health research community.

The response in the decade that followed featured the creation of several new global organizations, and increased attention to the strategy of “essential national health research” (ENHR). The overall achievements were assessed at an international conference held in Bangkok in October 2000.

While there has been some progress at the country level, the overall situation remains unchanged. For example, in 1998 the global investment in health research was just over \$US 70 billion; of this amount about \$US 3 billion was spent on research relevant to 90 per cent of the world’s population—a situation now commonly referred to as the “10/90 disequilibrium”. In other words, about \$US 67 billion was invested on research on the health problems of 10 per cent of the world’s people, almost all of whom live in high income countries.

A small number of Canadians attended the Bangkok conference, and felt that the Canadian response to this situation was unsatisfactory. A consultation process was begun to explore the interest and potential contributions of

Canada to global health research. In November 2001, four federal funding agencies signed a memorandum of understanding to support a “global health research initiative”. The agencies are the Canadian Institutes for Health Research (CIHR), the Canadian International Development Agency (CIDA), the International Development Research Centre (IDRC) and Health Canada (HC).

At the same time, a broader “Coalition for Global Health Research - Canada” (CGHRC) was created to enlist a broader range of Canadians in this effort, to include universities, non-government organizations (NGO’s) and others. Its purpose is to raise awareness about the “10/90 disequilibrium”, and to mobilize increased Canadian involvement in global health research.

Since its creation in September 2001, the CGHRC (including representatives of the four federal agencies) has embarked on a several activities. Working groups have taken on specific tasks—an example is a concept paper of Canada’s role in global health policy and systems research. A web-site has been developed (www.cghrc.ca). A \$ 1 million fund has been created to support one-year planning and program development partnerships between Canadian groups and research teams in low and middle income countries. Much of the funding comes from several CIHR scientific institutes that have realized the importance of a global component in Canada’s health research portfolio.

A special advocacy initiative was undertaken in connection with the G8 Summit, which this year was hosted by Canada, in Kananaskis in June. A major item on the G8 agenda was the “New Partnership for African Development” (NEPAD). The CGHRC saw this as an

opportunity to make the case that the health research system in Africa needs a massive increase in support by the “rich nations” represented in the G8. Working closely with Canadian government officials, who were responsible for much of the G8 agenda, a process was launched with the aim of including a recommendation about African health research in the Africa action plan.

An intensive e-mail dialogue began, working toward the preparation of a recommendation, supported by a compelling 7-page background document. In April, a 3-day consultation meeting was held in Toronto, which included some eminent African health researchers. Remarkably, Canadian government officials presented the CGHRC documents to the “agenda setters” of the other G8 nations, with the result that this item was included in the final agenda.

The result was that the G8 Africa Action Plan of the Kananaskis Summit included the following statement:

“Supporting health research on diseases prevalent in Africa, with a view to narrowing the health research gap, including by expanding health research networks to focus on African health issues, and by making more extensive use of researchers based in Africa.”

The Canadian government has designated CIDA as the agency to manage a special “Canada fund for Africa”, created to support actions resulting from the G8 summit. Discussions are currently underway, both within CIDA, and with African health research partners, about some “next step” activities to move the process forward.

CANADA STRENGTHENS GLOBAL RESEARCH

The CGHRC will host a day-long workshop on October 27th in Ottawa, in conjunction with the 9th Canadian Conference on International Health (CCIH-9). Further information about the CGHRC can be found by accessing the website (as above). Information about the CCIH-9 can be ob-

tained through the conference website: <http://www.csih.org/what/conferences.html> ♦

Prepared by Vic Neufeld, MD, member of the CGHRC; neufeld@mcmaster.ca

1. Commission on Health Research for Development. *Health Research: essential link to equity in development*. New York: Oxford University Press, 1990.

2. Neufeld V, MacLeod S, Tugwell P, Zakus D, Zarowsky C. The rich-poor gap in global health research: challenges for Canada. *Canadian Medical Association Journal* 2001;164 (8):1158-59

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AFTER ROMANOW, WHAT?

As we go to press, the Romanow Commission is scheduled to report to the Prime Minister in early November. But we are still a long way from the promise to modernize Medicare for the 21st Century. Join us for a panel discussion of options and strategy...

FALL MEMBERS MEETING

Tentative Date

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