

MEDICAL REFORM

Newsletter of the Medical Reform Group

Issue 126

Volume 23, Number 1

Summer, 2003

MOVING FORWARD ON PUBLIC HEALTH IN CANADA: SPRING MEMBERS MEETING

Despite one false start owing to concerns around SARS in the Toronto area, members met Thursday, June 12, 2003 for an educational session on public health, led by Dr. John Frank, Scientific Director of the Canadian Institutes of Health Research Institute of Population and Public Health.

According to Dr Frank, public health is both the science and the art of promoting health, preventing disease and prolonging life through the organized efforts of society. Frank went on to describe some of what he and his colleagues have learned about public health in Canada, acknowledging the many successes of public health approaches in the last century, including:

- Vaccination and control of infectious diseases;
- Motor vehicle safety;
- Safer workplaces;
- Fewer deaths from stroke and heart disease;
- Food and other product safety
- Fluoridation of drinking water;
- Recognition of the health effects of tobacco.

Although this track record sounds impressive, an examination of recent potential public health disasters in the last number of years has both the public and experts wondering if we are taking prevention issues seriously enough.

To try and address this issue, Frank summarized the work of one of the Institute's study groups who set out to

draw lessons for Canada from public health experience around the world.

What they learned

1. Public health is different than health care services delivered to individuals. This has a number of implications. Individual patients are more likely to think in terms of outcomes for example in response to various 'individual' interventions—surgery, drugs, and the like rather than to appreciate the benefits of clean air, clean water or safe food. In this context Frank registered his disappointment with Romanow and Kirby, authors of two of the most recent assessments of health care in Canada for their almost exclusive focus on the care system rather than the health system.

2. If we continue to think of public health as being delivered predominantly at the municipal or even provincial level, we will continue to have great differences in the range and quality of service delivered. Citing the Statistics Canada 2003 Community Health Survey, he showed how provincial distributions of obesity and smoking followed regional fiscal capacity. For the foreseeable future, smaller, poorer and more rural areas will have difficulty marshalling human and material resources to address infectious diseases and basic food and water safety issues, let alone manage making an impact on chronic disease or many of the emerging conditions which have been the focus of media attention in the past couple of years.

3. Without adequate data, appropriately [dis]aggregated, researchers and policy analysts will be less able to intervene in a timely way to design policy to accommodate emerging conditions. In this connection, Dr. Frank reminded members of how, until recently, gender differences in heart disease, a prevalent condition, were missed.

INSIDE

Guyatt Columns.....	3-6,14-15
Letters.....	12, 13, 16
Tuition Fees	8-12
Iraq.....	6-7

Please visit our web-site:
<http://www.hwcn.org/link/mrg>

Recommendations

In the context of the recent announcement of federal and provincial

(continued on page 2)

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.

MOVING FORWARD ON PUBLIC HEALTH IN CANADA (continued)

task forces to review capacity in public health, Frank completed his presentation with a number of recommendations for the consideration of the membership:

1. **Jurisdiction:** although it may make sense to deliver direct care services to patients at a local or provincial level, there is a logic to designing a NATIONAL public health system, which would enable a more coordinated, consistent, comprehensive approach to:

- Legislative Organization and Governance Structures; ·
- Accountability Mechanisms; ·
- Budgets for Public Health; ·
- Workforce Planning and Development; ·
- Information Management; ·
- Research and Development; ·
- Supporting Capacity of Smaller/ Remote Agencies; ·
- Specific Public Health Infrastructure Initiatives.

2. **Accountability:** Consider the institution of a Surgeon-General or Chief Medical Officer of Health who would report, like the Auditor General to Parliament and not to a Minister or Cabinet, in whose interests it may often be to gloss over issues uncomplimentary to the government of the day.

3. **Human Resource Planning, Development and Management:** Accountable national level approaches to public and population health would facilitate resource sharing and the development of expertise for the whole country, not just a few major population centres. An alternative delivery model might be the Quebec National Institute of Public Health. This institute has recently

facilitated the emergence of CLSCS as a major player in the delivery and training site for Quebec's public health system, through the use of data and strategic planning. It also played a role in instituting sessional billing, by CLSCs, for the delivery of public health programs.

4. **Modernizing information systems:** Similarly, the design of a national level system should facilitate the collection of more useful data in a more timely way, with the potential to improve research and evaluation of prevention responses, and speed up strategic development to address chronic and emerging issues with an adequate evidence base.

5. **Cross-sectoral policy potential:** While the effects of a weak public and preventive are most visible in care and mortality data and the like in the health sector, at least some components of the solutions to those findings will lie outside the health sector. For example, the recent Walkerton inquiry demonstrated amply the need to keep in mind not only water testing and treatment at the well, but changes in land use regarding the intensification of agriculture. Similarly, the impact of SARS on Toronto is due in no small measure to Toronto's significance as a travel nexus both nationally and internationally.

The Steering Committee will be reviewing the options outlined by Dr. Frank over the summer and making recommendations for updating policy. Watch the next newsletter for developments. ♦

MORE SPENDING DOESN'T ALWAYS MEAN BETTER HEALTH CARE

Consider the following headlines. “Hospitals overcrowded, patients wait in emergency for scarce hospital beds”. “Intensive care units near capacity, doctors frantic.” Both sound like bad news, right? Maybe, but maybe not.

In Canada, out-of-control health care spending is a myth. As Canadians, we spend less of our resources, as represented by the Gross Domestic Product, on health care than we did ten years ago. Spending per-person on doctors and hospitals has not changed over that decade.

At the same time, pressures on health spending are real. Highly trained health workers demand high salaries. Often, new technology generates increased costs. The bottom line is an international trend toward increases in health care spending that began about 40 years ago and shows no sign of ending. Cost pressures mandate that we spend our health resources as efficiently as possible.

In considering the efficiency, we should ask how much we gain when we increase health spending. An important new study from the U.S. suggests that the answer is, sometimes, not much.

The US Medicare program covers physician and hospital services for people over 65 the way that Canadian national health care covers doctors and hospitals for our entire population. As it turns out, American Medicare expenditures vary dramatically across the country. For instance, Medicare spent \$8,414 per enrollee in Miami in 1996, compared to \$3,341 in Minneapolis.

A group of researchers have asked whether high-spending areas get better quality of care, or superior health outcomes, for the extra money.

The researchers divided the US into five regions according to Medicare spending. Yearly per-person Medicare costs in the top-spending region were \$6,304, and in the lowest-spending region \$3,922. In other words, residents in the top-spending region received 62% more Medicare resources than those in the lowest-spending region.

The study team looked at four groups of patients. Three groups had experienced a serious illness – a heart attack, a hip fracture, or a new diagnosis of colon cancer. The fourth group was a random sample of Medicare recipients. For each group, the investigators looked at measures of quality, satisfaction with care, and death rates. What did the big spenders get for their money?

Regions with higher expenditure indices did not, in general, do any better on measures of good health care. For instance, of four classes of drugs that reduce death rates after heart attacks, there was no difference in two, patients in high spending regions were more likely to receive a third, but less likely to receive the fourth. Patients in high spending regions were less likely to receive preventative measures such as influenza immunization or pap smears.

What about access? Patients in the high-spending regions were more likely to see a specialist, patients in low-spending regions more likely to see a family doctor. But waiting times were longer in the high spending areas. Furthermore, patients in the high-spending regions were no more satisfied with their care.

The ultimate goal of health care is improved health. Did increased health spending reduce death rates? Spending did not effect the risk of dying in the random sample and hip fracture groups. Death rates in patients with colon cancer

and heart attacks went up, not down, with increased spending.

To fully understand the results, we should know where the extra money was spent. The big differences were in higher rates of hospitalisation, more tests and minor procedures, and seeing more doctors, particularly specialists. Some of the biggest differences were in care reserved for the sickest patients, such as use of artificial breathing machines.

These results provide a message about how to deliver efficient health care. Doctors use the resources available to them. Open more hospital beds, or more beds in intensive care units, and doctors fill them. In other words, when more beds are available, doctors apply a lower threshold for admitting patients to those beds.

The results suggest that the Canadian system of rationing care, in which we make sure hospitals and intensive care units operate at full capacity, makes sense. At the same time, we must remember that Canadian health care spending is already at the level of the lowest-spending American regions. Patients needing hospital admission often spend hours to days waiting for scarce hospital beds. Intensive care units are frequently full, leading to cancellations in elective surgery. Waiting times for heart catheterization and radiation therapy suggest that targeted increases in funding are necessary to ensure optimal care.

How tight can we run the system before quality does deteriorate, and patients suffer worse health outcomes? No one knows the answer, and even if governments allocate adequate funds for health care delivery, health care planners will struggle to find the right way to spend the limited money.

Nevertheless, the American study suggests that health care Commissioner

(continued on page 4)

IS MEDICALIZATION A THREAT TO HEALTH?

In an increasingly common way of looking at the world, every one of us is ill.

At any given time, a small minority of Canadians are experiencing an acute illness, from a mild cold to severe pneumonia. A much larger proportion suffers from a chronic illness such as diabetes or emphysema. Typically, such chronic conditions require careful monitoring and care.

Many others feel well, but have learned from their doctors that they have a medical condition requiring treatment. For instance, many Canadians have received a diagnosis of high blood pressure, otherwise known as hypertension. Hypertension increases your risk of stroke and heart attack, and treatment lowers that risk.

Another common condition is abnormal composition of fats in the blood, known as high cholesterol. High cholesterol also increases the probability of heart attacks, and treatments that lower cholesterol decrease that probability.

MORE SPENDING (continued)

Roy Romanow got it right when he didn't focus on hospitals. Instead, he wisely recommended targeted new public spending on home care, protecting Canadians from catastrophic expenditures on prescription drugs, up-to-date diagnostic technologies, and strengthening primary care.

So, next time you see those frightening headlines about tight hospital services, think twice. They may mean we are making wise decisions about efficient use of health care dollars. ♦

First appeared April 4, 2003 under the title of Making Wise Use of our Canadian Health Care Dollar, as one of Dr. Guyatt's twice monthly columns in the Hamilton Spectator.)

The common denominator in these conditions is increased risk. We find a marker of increased risk, such as blood pressure or cholesterol, and if we treat the marker, risk of bad outcomes such as stroke or heart attack decreases.

We are finding more and more such markers, and more treatments to decrease risk. For instance, many older people suffer fractures of their bones. The most serious is a hip fracture. Researchers have found that thinning of the bones increases the probability of fracture, and treatments that strengthen bones decrease the probability.

For some conditions we consider everyone at risk. Most industrialized countries have accepted that women over age 50 should have regular mammographic screening for breast cancer. Evidence suggests that regular screening from colon cancer can decrease colon cancer death rates, and advocates suggest screening for the entire population over age 50.

Even if we aren't sick because we have a "disease" like hypertension, or osteoporosis, we may have one of a number of conditions that are increasingly being characterized as illnesses.

We all get episodes of diarrhoea, constipation or abdominal pain, some of us more often than others. When these symptoms are severe and occur most of the time, doctors use a label of "irritable bowel syndrome". But, since everyone has the symptoms on occasion, where is the dividing line between who is normal, and who is "diseased"?

Emotional problems are subject to this same medicalization. Serious depression is a personal disaster and drugs can have crucial benefits. But when does unhappiness become depression that warrants treatment? Recent drug company campaigns label excessive shyness as "social phobia", a disease that may warrant drug treatment.

Aging is inevitably associated with loss of youthful appearance, and declining function. When we start to treat what used to be considered as the normal consequences of aging, we treat getting older as a medical condition. Hair loss, or declining sexual function, are good examples. Sildenafil citrate, commonly known as Viagra, an impotence treatment, has become the pharmaceutical industry's biggest success story ever.

There are clear benefits to these trends. The drugs we give for high blood pressure and cholesterol have prolonged productive lives, and screening has prevented premature deaths from breast and colon cancer. Viagra has increased sexual satisfaction and improved well-being.

Still, there are down sides to medicalization. All treatments, and many tests, have common mild side effects, like headaches or fatigue. In addition they may have other side effect that are rare but very serious.

A small number of patients treated with cholesterol-lowering drugs have, for instance, died from severe muscle damage. Rarely, patients taking a drug for irritable bowel syndrome have died from bowel inflammation. Women with suspected breast cancer have had biopsies that showed no cancer, but have caused serious breast infections.

We must also consider monetary costs. Drug treatments and screening are expensive. The costs and side effects become increasingly questionable when applied to patients at low risk.

There are other less obvious downsides to medicalization. Focusing on lowering our risk of heart disease, stroke, or colon cancer, we may come to see ourselves as walking time bombs. What does that do to our sense of well-being?

(continued on page 5)

IS MEDICALIZATION A THREAT TO HEALTH? (continued)

Minor and sometimes major pain and discomfort, aging, decline and death are all part of life. We may try to escape pain and discomfort, ward off serious illness, and delay our death. But our efforts are ultimately doomed, and our successes temporary.

Medical therapies have contributed enormous improvement in quality of life. Preventing serious illness and death is often worth cost, minor side

effects, and small risks of serious complications.

But have we gone too far? Is our medicalized culture, focused on avoiding aging and unpleasantness, alienating us from a basic part of what it means to be human? Could it be that we end up suffering more in our attempts to escape illness and decline? Would we suffer less anguish if we accepted the inevitable, and learned to live comfortably with our

vulnerability, and with the normal aging process?

If the answer is yes, that in striving to retain health at all costs, we become more and more sick, we must ask what are the forces that are driving medicalization. And what, if anything, can we do about it? ♦

*First appeared May 2, 2003 under the title of Aging and Pain are Part of Being Human, as one of Dr. Guyatt's twice monthly columns in the **Hamilton Spectator**.)*

HOW TO KEEP A HEALTHY STATE OF MIND

People living in countries with the longest life span, and the best medical systems, report that they are substantially sicker than those in countries with shorter life spans, and poorer medical care.

For instance, people in the United States, where average life expectancy is about 75, report more than three times the illness frequency of those in India, with an average life expectancy of just over 60 years.

Are Americans sicker than Indians? Almost certainly not.

Part of the reason for the difference is American's better education, and disease detection.

Some reasons for increased perceptions of illness may not be so positive. As this column has described in the last month, Canadians are increasingly seeing themselves as being sick with conditions such as irritable bowel syndrome, baldness, social phobia or generalized anxiety disorder. Some have serious problems that merit the label of disease. Many, however, suffer minor complaints that people in other cultures would simply consider part of life.

For instance, while an Indian responding to a survey wouldn't think of mentioning intermittent diarrhea, Americans with the same symptoms might report that they have irritable bowel syndrome.

In Canada, virtually the entire adult population can see themselves as being ill with one disease or another. Is this a desirable situation? Because of risks and costs of drug treatment, problems with disease labeling, and destructive impact on how we see ourselves, we may be going too far with medicalizing our lives. Who is responsible for the epidemic in disease-labelling, and what can we do about it?

In Canada, over 9 per cent of our economy is devoted to delivering health care. In the US, the figure is 14 per cent. Drugs account for about 16 per cent of those expenditures. So, in Canada we spend over 1 per cent of our gross domestic product on pharmaceuticals, while the US spends over 2 per cent. That is why, worldwide, the international pharmaceutical industry revenue is greater than Spain's GDP.

From an industry-eye-view, the ideal drug is one that we must take all our lives. The more chronic illness we think we have, the better, from the drug company profit point of view.

No wonder, then, that the industry has played a major role in the creation of new diseases, and in persuading as many people as possible that they suffer from "diseases" such as female sexual dysfunction and osteoporosis.

Since 1997, the American drug industry has had a powerful new weapon

for disease-creation. That's the year the Food and Drug Administration (FDA) eased restrictions on direct-to-consumer advertising (DTCA). Anyone watching ads on American television won't be surprised that the industry spends about \$2.5 billion yearly on DTCA.

While DTCA is illegal in Canada, the Therapeutic Products Directorate, Canada's FDA equivalent, is thinking of changing laws to allow DTCA. One strategy for fighting medicalization is to keep DTCA out of Canada.

Kathleen O'Grady is the Director of Communications for a non-profit public education group, the Canadian Women's Health Network. Ms. O'Grady reports regular offers of sponsorship for the group's consumer health education efforts from public relations firms representing the pharmaceutical industry.

The industry hopes, through its generosity, to influence the organization's message. Ms. O'Grady, knowing that accepting the money would indeed affect their message, always refuses.

Many other community organizations are not so scrupulous. A second way to fight medicalization is to be skeptical when you hear of community groups fighting for recognition of new illnesses, and greater access to drugs.

(continued on page 6)

HOW TO KEEP A HEALTHY STATE OF MIND (continued)

Look for acknowledgement of industry funding. If you find a statement that the group is not supported by industry, it's good news. If you find no such statement, it is likely that industry financial support has influenced the organization's message.

You should look with the same skeptical eye when prominent physicians present worrisome information about a new medical condition. "Is this doctor a paid consultant to a pharmaceutical firm?" is a question that should enter your mind.

Drug companies aren't the only ones to benefit from health care expenditures. The US recently reversed an expert panel's recommendation against screening women under 50 for breast cancer.

The evidence for the effectiveness of screening in women under 50 is weak. Furthermore, even if screening does work, delaying one breast cancer death would require screening well over 300 women for 10 years.

Of 1,000 women screened, about 400 will have a false positive result requiring a breast biopsy. A small proportion of these women will have complications of the biopsy. The fear, worry, complications and expense are almost certainly not worth the uncertain benefit.

Women's groups and radiologists doing mammographic breast cancer screening were among the groups behind the public outcry against the expert recommendations suggesting no screening for women under 50.

Here, the motivation is more complex than the pharmaceutical industry. But the bottom line is once again an unhealthy decision that focuses women on their medical risk.

So, a final weapon against medicalization is skepticism about screening or treatment programs to prevent distant events in people at very low risk.

Canadians living in 2003 are among the healthiest group of people to ever walk on earth. We will be healthier still if we can see ourselves that way. ♦

*First appeared May 30, 2003 under the title of Have We Gone Too Far in Medicalizing Our Lives? as one of Dr. Guyatt's twice monthly columns in the **Hamilton Spectator**.)*

GETTING HIGH QUALITY INFORMATION ON WHAT'S GOING ON IN IRAQ

Earlier this spring, Janet Maher interviewed Toronto area family physician and MRG member Dr. Jane Pritchard, on her experience at a Peacemaker in Iraq on the eve of the war.

JM: How did you come to go to Iraq?

JP: I have been a member of the Canadian Peacemaker Teams (CPT) since 1991. CPT is a violence reduction programme of the Mennonite, Quaker and Brethren churches initially, now with wider Christian affiliation, whose first destination was Iraq in December, 1990, just before the (first) Gulf War.

I first participated as part of an exploratory team that went to Israel and the West Bank under curfew in 1991, then in 1997 to Chiapas, Mexico, just after paramilitary assassinations of a civilian pacifist community of refugees. I decided

to devote more time to CPT and took the 3 week training in non-violence in 2000, then served in Esengoopeitij (Burnt Church NB) during the contested lobster fishery.

In October, 2002, CPT was invited to Baghdad by "Voices in the Wilderness", an American group of nonviolent activists which had been in Iraq since 1995 with the purpose of ending the U.N. sanctions which were having such a devastating effect on the civilian populace.

JM: Describe your work there. What were your objectives? Who were the other people in your team and what did they do? What did you find?

JP: Our objective in Iraq was really to find out what was happening, inform the Canadian and American public of the probable consequences of the war which was threatened, and urge them to

pressure their governments to avoid war and to end sanctions. Our team of 15 included 3 Canadians, 9 Americans and 3 Europeans who met in Amman, and drove across Iraq.

We connected with the UNDP and CARE in Baghdad, travelled to Mosul, visited hospitals, orphanages and several churches, and spent time in the homes of Iraqi families. We participated in several public actions to highlight what was going on in early 2003.

Among the actions were:

- Activities to support weapons inspection activities We welcomed Hans Blix to Saddam International Airport. A group of about 30 of us went daily to the UN offices with a banner urging "inspections -yes; invasion, no".

Our group recognized the
(continued on page 7)

GETTING HIGH QUALITY INFORMATION ON WHAT'S GOING ON IN IRAQ (continued)

difficulties faced by the weapons inspection team, who faced intense political pressure to report in a manner to justify invasion. We got good media coverage from European, Japanese, Chinese and Arab outlets, less from North Americans, though there were not many of the latter on the ground in Iraq.

For me, it was only in Iraq that I got a sense of European peace activism, which was also reflected in their media.

Visits to check on civilian infrastructure. Water plants and power plants were significantly targeted in the first gulf war and our group was concerned about the potential for water contamination in particular. Our work was focused on a couple of specific plants, again with banners suggesting targeting those sites would be tantamount to war crimes. In general, I think fewer civilian targets were hit this time.

Although I was only there for a few weeks, some of our team members have remained, and aside from a couple of weeks when they were evacuated, we have continued to have daily contact with them and with European and other non-North American media.

Ordinary Iraqis told us that what was killing them even more than the bombs were sanctions. In recent years, many professionals have abandoned their professions for jobs which would allow them to put food on the table. The result is that hospitals for example are sparse not only in supplies like antibiotics and blood bags, but also in staff. School teachers could not afford to work for the equivalent of \$6 U.S./month and so left the classroom.

I understand there is a lot of debate on the specific effects of

sanctions, but some specifics. Polio vaccine was on the sanctions list till several cases of polio were reported in 1999; a few months ago, most chemotherapeutic agents, and ciprofloxacin were added. Nominally these agents all had "dual use" potential (i.e. biological warfare). Meanwhile, childhood cancer rates had tripled in Iraq since 1991, and increased by a factor of 17 in Basra, presumably due to residual effects of depleted uranium, and other toxic residues from the bombings of (and since) 1991.

JM: Do you have any idea what is happening now that the war is nominally over?

JP: Four of our team members are still there and we are in daily contact. They are very frustrated at the lack of police and security in spite of the presence of occupying forces, especially around the Oil Ministry. There have been a number of injuries relating to unexploded munitions. The other day, our group was in touch with an NGO trying to deliver hospital supplies who arrived as the hospital was being looted. In this particular case, they were able to leave and return later, otherwise who knows where the supplies would have ended up.

There are 40,000 US troops still in Baghdad, but almost no order. These troops are only trained to attack not to police and the looting continues. They are formally in control of all of Baghdad except for one Shiite suburb.

Any time we phone, the sound of gunfire in the background is continuous, and there are continuing complaints of difficulties in delivering food and medical supplies. When our team members approached soldiers to cordon off piles of unexploded munitions in the streets, they were told they had run out of orange tape.

Thus began a campaign in the US of mailing rolls of orange tape to the Pentagon to assist with their policing obligations. CARE has given up trying

to deliver without armed guards, which adds both to the time and cost of the work. In early May, there were reports of 2,000 children daily being admitted for treatment of diarrhea to Baghdad hospitals. According to UNICEF reports from late May, the prevalence of acute malnutrition in young children is nearly double what it was one year ago.

JM: How can we sift fact from fiction in the media reports?

JP: I think our solution has been to rely on as many sources as possible and be aware of the potential for bias in each of them, for example the Guardian and the BBC which would normally be well regarded. Also it is useful to know who actually has journalists in the field, rather than in Jordan or other nearby countries, and which are unembedded. We also follow the alternative electronic media from most countries.

JM: What can Canadians/MRG members do?

JP: I think the need to undo the sanctions is really urgent. Canadians should do all they can to focus attention on the need for the UN to return in a major administrative role to require accountability of the US and the UK.

There will be a rebuilding phase and the Quakers, led by Dr. Dale Dewar of Saskatoon expect to organize a shipment of medical supplies for September. The other useful thing that can be done by medical people is to assist in transmission of medical information. By comparison with many parts of the world, there are a lot of highly trained physicians in Iraq but the period of sanctions has been difficult in that all medical and scientific journals were not allowed into the country. ♦

THE COSTS OF MEDICAL SCHOOL: ARE RISING TUITION FEES GOING TO AFFECT HEALTH CARE DELIVERY?

Irfan Dhalla, Jeff Kwong and Ian Johnson

Twenty years ago, medical students at the University of Toronto paid \$1,590 in tuition fees per year. This fall, entering students will pay more than 10 times that much—\$16,207 (see Figure 1). Add in living costs and a four-year medical degree easily costs more than \$100,000.

Tuition fees may be more unaffordable now than at any point since Confederation. By studying both the costs of medical school and the wages of the working class, a professor at Queen's has estimated that a carpenter would find funding medical school for a child more unaffordable now than that at any time since at least the 1870s.

So what effects do increasing tuition fees have? Does the number of students from lower-income families decrease when fees rise? Do students assume more debt? And if so, does this affect their career choice? And what happens to support for a public health-care system? These were the questions we set out to answer in the summer of 2000.

Our review of the literature revealed that the effects of increasing fees had never been examined in Canada. Anecdotally, however, concern had been expressed that accessibility was being compromised. Several American commentators have also argued that high tuition may restrict access to medical education for those from low-income families, underrepresented minority groups and rural areas.

Due to the lack of Canadian data, we conducted a survey of Canadian medical students early in 2001. We sought to examine the effects of rising tuition fees on medical student demographics by comparing medical students in Ontario with those attending other Canadian medical schools, where tuition fees have remained relatively stable.

Our questionnaire focused on medical student demographics, socioeconomic status, and the influence of financial considerations on career choice. To allow for direct comparison with the Canadian population, several questions (for example, visible minority status, educational attainment) were virtually identical to those asked in the 1996 Canadian census. The survey was pre-tested and then conducted over the internet. Due to difficulties in obtaining accurate medical student lists in Quebec, we were unable to include Quebec data in our analysis.

Among the twelve Canadian medical schools outside Québec, 1,223 undergraduate medical students entered medical school in 2000. We received responses from 981 of these students, for a response rate of 80.2 per cent.

Let's start with the positive results: a generation ago, almost all medical students in Canada were white men. Looking around a medical school class today, it is easy to see both ethnic and gender diversity. Our findings confirmed this—slightly more than half of the respondents were female, and almost one-third identified themselves as a visible minority.

Look more closely, however, and a few glaring gaps emerge. For example, just 0.7 per cent of medical students claim aboriginal status, compared with 4.5 per cent of the Canadian population. Only 10.8 per cent of medical students lived in a rural area at high school graduation, compared with 22.4 per cent of Canadians. The socioeconomic diversity of the population is also not reflected in the medical student population. We found that someone growing up in a high-income neighbourhood is seven times more likely to end up in medical school than someone growing up in a low-income neigh-

bourhood. More than half of medical students reported parental income greater than \$80,000, compared with just one-fifth of an age-matched sample of ordinary Canadians.

When we looked at changes between 1997 and 2000, we found that medical student family incomes had increased in Ontario, where tuition hikes have been most dramatic, while remaining stable in the rest of the country (see Table 1). It should be noted, however, that the difference in Ontario was not statistically significant when compared with the difference in the control schools.

The rest of the differences we observed were highly statistically significant. Over 80 per cent of medical students expected to graduate with debt both in Ontario and in the rest of Canada, but median anticipated indebtedness in Ontario rose from \$57,000 in 1997 to \$80,000 for 2,000 enrollees. Outside Ontario, this figure remained stable at \$50,000.

In Ontario, the number of students who said that financial considerations would be a major influence on their choice of specialty doubled (from 13.3 to 25.4 per cent), and the number who said finances would be a major influence on their practice location increased by 35 per cent. Neither of these changes was observed outside Ontario.

We believe our findings are worrisome and should be addressed by governments, medical schools and the physician community. Reductions in provincial funding of post-secondary education and increases in student enrolment have left Ontario universities with few choices. All have raised tuition for their professional programs, though some increases have been buffered by

(continued on page 9)

THE COSTS OF MEDICAL SCHOOL: ARE RISING TUITION FEES GOING TO AFFECT HEALTH CARE DELIVERY? (continued)

increased financial aid. For example, a multimillion dollar donation has allowed Queen's to give 189 out of 221 bursary applicants an average of almost \$8000 each. We cannot, however, rely on the generosity of a few individuals to ensure that physicians come from all geographic, ethnic and socioeconomic backgrounds. We worry most about three issues. First, accessibility. If you grow up on an aboriginal reserve, for example, is obtaining a \$100 000 medical degree realistic? Our data show that even when tuition fees were relatively low, the number of doctors from lower-income families or aboriginal communities was small. Increasing tuition fees will certainly not increase the number of lower-income students who can afford medical school.

Aside from issues of equity, medical student diversity is also beneficial for pragmatic reasons. Studies have shown that students from

underrepresented groups are more likely to treat ethnic minorities, practice in rural communities, and work in socioeconomically depressed areas.

Second, career choice. Can medical students with huge debts afford to spend their summers doing electives or research that get them the highly coveted reference letters that are increasingly necessary for landing a desirable residency?

Are increasing tuition fees going to affect what future graduates do? Is a research career going to be lucrative enough to pay off a six-figure debt? Could a new graduate afford to spend some time abroad, doing humanitarian work for an organisation like Médecins Sans Frontières? Very little information exists on whether increasing tuition fees affect career choice and work patterns, and the tuition fee increases in Ontario are too recent for any effect to have yet been felt.

Finally, and perhaps most importantly, will increasing tuition fees erode support for a publicly funded health care system among tomorrow's physicians? Michael Gordon, physician-in-chief at the Baycrest Centre for Geriatric Care, has stated that he feels the single greatest threat to the Canadian health care system is high tuition fees. Why? Physicians who have had their education paid for by society will likely want to repay that debt. Doctors who feel they have footed the bill might have a certain sense of entitlement, and consequently expect more freedom and compensation.

Some people have speculated that increasing tuition fees may be contributing to the declining interest in family medicine as a career. Will increased tuition fees change the way future physicians practice? Will the "sticker shock" of high tuition lead to even fewer doctors from underrepresented groups?

Clearly, ongoing studies are needed to determine the long-term effects of rising medical school tuition fees, and actions need to be taken by universities and governments to limit any effect the increased cost of medical education may have on tomorrow's doctors and the future health care system. ♦

Ian Johnson specialized in community medicine and is an assistant professor in the Department of Public Health Sciences at the University of Toronto.

Jeff Kwong is a community medicine resident at the University of Toronto.

Irfan Dhalla graduates from medical school in June and is starting an internal medicine residency at the University of Toronto.

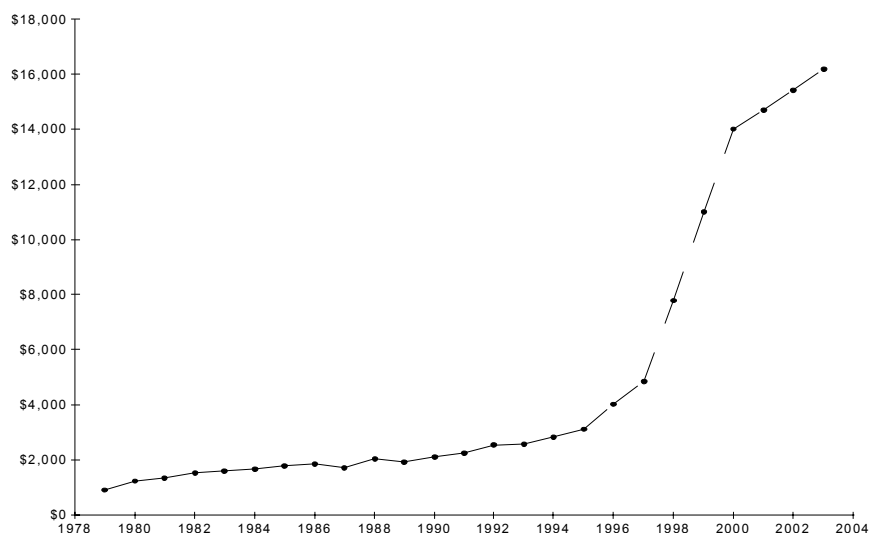


Figure 1. Tuition fee for first-year medical students at the University of Toronto, 1979-2003.

THE COSTS OF MEDICAL SCHOOL: ARE RISING TUITION FEES GOING TO AFFECT HEALTH CARE DELIVERY? (continued)

Table 1. Reported family income of Ontario and control respondents, 1997 and 2000.

		< \$40K (%)	\$40 - \$80K (%)	\$80 - \$120K (%)	\$120 - \$160K (%)	> \$160K (%)
Ontario						
	1997 cohort	22.6	29.3	21.1	9.8	17.3
	2000 cohort	15.0	29.8	22.8	13.5	18.8
Rest of Canada						
	1997 cohort	16.0	34.3	26.1	10.4	13.1
	2000 cohort	15.8	32.1	26.4	10.5	15.2

A MEDICAL CAREER: SOON TO BE: “THE INACCESSIBLE DREAM”

As a newly graduated medical student, I was recently invited to a career fair to speak about medicine and my path to becoming a physician.

There were many fields represented at this career fair. While speaking to the eager, attentive students, I spoke with pride about becoming a physician and the many benefits that this profession entails. I watched as the students began to have a sense of hope about their future and open up and ask questions about becoming a doctor.

However, shortly thereafter I was overcome with an uneasy feeling in the pit of my stomach. As I began to take a closer look at the children I was speaking to, I realized that I was not telling the whole truth. Becoming a physician is no longer for those individuals who are honest, who have integrity, the drive to work hard, strong interpersonal skills and the desire to help others.

The medical profession is becoming closed to individuals who have the above qualities, unless of course, they come from the upper socioeconomic class. According the article by Irfan Dhalla, Jeff Kwong, and Ian Johnson, in 1997, over 50 per cent of Ontario medical students came from households where the household income was less than \$80, 000.

In 2000, that number dropped to 45 per cent, with the most significant drop being at the less than \$40,000 range. If medical tuition continues to rise, the accessibility of medical school for students from the lower socioeconomic class will disappear.

As that group disappears, any chance that the medical profession has of attaining diversity that mirrors the Canadian population disappears as well. Since I am a black medical student, I was asked by Irfan Dhalla to give my perspective on this issue. Although hesitant, I accepted this request because I realized that I would be doing a disservice to all students that come from middle to low income families and nurture hopes of becoming a doctor. And so I have decided to share my story and my opinions.

As I enter the first year of my residency training, my debt greatly exceeds \$100, 000. It has reached the point at which my financial institution considers me to no longer be eligible for an increase in my personal line of credit. I shudder to think what may have occurred had I begun the path to becoming a physician two years later. The tuition in my first year of medical school, was around \$8,000; it is currently greater than \$16,000. As I understand it, there is no reasonable end in sight to these increases. Using these numbers, if I had

started medical school two years earlier, I would have hit my maximum allowable debt sometime in the third year of medical school.

This would have made it almost impossible to complete my clerkship. Not to mention, this financial situation would have handicapped my ability to perform at a level worthy of attaining the residency of my choice.

The University of Toronto and the Medical Alumni Association has been absolutely wonderful in helping me with grants, bursaries and summer scholarships. I cannot say enough about the Student Affairs Office and the Admissions and Awards Office as well as many of the administrators at the University of Toronto that have helped me along my path to becoming a physician. These individuals are unequivocally dedicated to helping students. However, there comes a point at which grants and bursaries can only do so much.

As tuition continues to rise accessibility to medical education is an important issue. As a result, I cannot speak to my friends and family members about their children pursuing a career in medicine, without explaining to them the financial burden that this route will entail. As I express this point of view, I am often met with statements

(continued on page 11)

A MEDICAL CAREER: SOON TO BE: “THE INACCESSIBLE DREAM” (continued)

such as: “Scholarships exist for students that cannot afford University.” My response is simple: “How many?” Unfortunately not enough, I would also argue that there are no scholarships that offer \$16,000 per year; not to mention the \$20,000 of living expenses that a medical student living in Toronto incurs.

I am a married student with a son and another child is on the way. This has added to my debtload, but many of the physicians that have been my mentors over the past four years, also had families while in medical school. Having a family should not in any way detract from my argument that the current tuition situation is out of control. My wife has helped to provide income as much as possible whenever possible. The fact that I feel it is necessary to defend having a family speaks volumes to medical school and the pressures it places on an individual.

My financial situation has become so precarious over the months leading up to my graduation, that I have not been able to meet my rent payments for several months. I am quite fortunate to have a very good relationship with my landlord; who assumes that I will be able to make good on these payments at some point in my future.

As the career fair progressed automotive technicians, lawyers, stock brokers, investment bankers, carpenters, hair stylists all took their turn at describing their journey which lead to them choosing their profession. I sat and listened in awe as members of the automotive industry explained that a student could be debt free at the age of 22 and earn approximately \$60 -75, 000 per annum.

Although I realize that becoming a physician is quite different from becoming an automotive technician, a carpenter or even a stock broker, yet to these students becoming a physician seemed almost ridiculous. Why would anyone choose to incur over \$100, 000

dollars worth of debt and be paying off their loans until they were approximately 40 years old? To help others you say? The fact remains that even the smartest, strongest well intentioned individuals without financial means will not be able to complete the journey of becoming a physician.

Some people have speculated that increasing tuition fees may be contributing to the declining interest in family medicine as a career. I'm not sure why that would be speculation. As I entered medical school, I felt as though I had accomplished a significant milestone.

My family was proud of my accomplishment. I was about to become the first physician in my family. It was not possible to make a bad decision in terms of my subspecialty. A family medicine residency seemed right. As a family physician, autonomy was paramount. Family practice would allow me to have the freedom to schedule my own hours, spend time with my family and have a diverse practice.

However speaking candidly with several family physicians who had debts that were significantly less than mine, I quickly realized that becoming a family physician was not the wisest decision for myself or my family. That was even before discussing the government restructuring plans for family practice. Luckily, I was able to fall in love with a subspecialty on route to choosing my future career: Anesthesia. I toyed with the idea of other specialties for the wrong reasons (for example,. annual income), however I realized that ultimately you must love what you choose and not settle due to other variables.

Although I was able to focus on the important reasons for choosing a subspecialty, it will be hard to assume that those behind me will be able to make decisions based on their suitability for various careers. Debtload and potential income earned by subspecialists will

necessarily become a greater factor in some students decisions to apply to certain residency programs.

The findings put forth by Irfan Dhalla, Jeff Kwong and Ian Johnson in their article are very worrisome. They posed several questions: Do the number of students from lower income families decrease when medical tuition fees rise? – ABSOLUTELY!

Do students currently assume more debt? – UNEQUIVOCALLY! (unless they come from families with high incomes).

Does the debtload affect career choice? – YES!

The final question: How will this change affect health care delivery? – remains to be answered. I project that eventually the percentage of lower socioeconomic students attempting to pursue a career in medicine will be very small. So what? Who cares? I can think of several reasons to care. The most obvious would be out of concern for fairness and equality.

Unfortunately, there will always be students lining up to fill residency spots regardless of medical tuition fees. As tuition increases, administrators will NOT have to worry about helping the financially disadvantaged graduate from professional programs because they just won't exist. The lower socioeconomic student will realize that the price of pursuing a career in medicine may be too great a weight to bear psychologically, emotionally and most frightful of all: financially. Those in favour of continuing tuition increases should consider the public perception of our profession. One of the big burdens that the field of medicine will have to bear if tuition increases do not stop will be that of public perception. In this time of intense public criticism and scrutiny, and as the doors close for the financially less fortunate (which often means for the

(continued on page 12)

A MEDICAL CAREER: SOON TO BE: "THE INACCESSIBLE DREAM" (continued)

visible as well as non-visible ethnic minorities), the public will begin to take an even closer look at the medical profession.

If I were to hazard a guess, I do not think that the public will have an increased appreciation for our closed door profession. Since it seems as though the argument for fairness and equality has been disregarded, I hope that those making tuition decisions, if nothing else, take into consideration the public backlash that may ensue toward physicians and put an end to tuition increases. ♦

Hance Clarke is a recent medical school graduate.

PRINCIPLES AND POLICY

Last issue we proposed some revisions to Medical Reform Group Principles and Policy. If you have comments, please let us know at mrg@web.ca. Next issue we'll review the feedback in preparation for the fall meeting. ♦

MEDICAL REFORM GROUP SEEKS POSITION OF REGULATORY COLLEGE ON MEDICALLY NECESSARY SERVICES

June 13, 2003

Dr. Rocco Gerace
College of Physicians and Surgeons of Ontario
80 College Street,
Toronto M5G 2E2
Fax: (416) 961-3330

Dear Rocco:

We are writing to ascertain College policy on a critical matter that we believe may soon require action.

As you know, the provincial government has awarded contracts to investor-owned private for-profit companies to establish Independent Health Facilities delivering diagnostic CT and MRI services. Public representatives have raised the possibility that these facilities will allow people to pay to jump the queue for medically necessary imaging.

Public representatives have also raised the possibility of people paying for screening CT and MRI that does not meet criteria for medical necessity. Technically, this would allow queue-jumping that would not violate the Canada Health Act that legislates against charges for medically necessary services.

Tony Clement has provided public reassurance that the facilities would not allow queue-jumping for medically necessary services. He has been curiously silent, however, on the issue of payment for screening scans.

As we understand it, the College has responsibility for the quality of services delivered by Independent Health Facilities. Screening CT and MRI scans are of unproven benefit, are potentially dangerous, and if not medically necessary would violate rules for services Independent Health Facilities are intended to deliver.

Tony Clement's silence on the matter of screening scans which patients would pay for out of pocket, and which would provide a profit margin for investor-owned facilities, strikes us as ominous. We would appreciate a statement from you regarding how the College would respond to information indicating that the new facilities were conducting screening CT and MRI scans for individuals providing out-of-pocket payment.

Thank you very much for considering this matter.

Gordon Guyatt for the Medical Reform Group ♦

AN OPEN LETTER TO FIRST MINISTERS OF HEALTH

May 18, 2003

The Honorable Anne McLellan, Minister
of Health
Brooke Claxton Bldg., Tunney's Pasture,
P.L. 0906C
Ottawa, ON K1A 0K9
Fax: (613) 952-1154

The Honourable Jane Purves, Minister of
Health
Province of Nova Scotia
4th Floor, Joseph Howe Bldg., 1690 Hollis
Street, PO Box 488
Halifax, NS B3J 2R8
Fax: (902) 424-0559

In early February F/P/T First Ministers met to consider the Senate and Romanow reports. As a result a new health accord was reached that increased federal transfers to the provinces (by \$34.6 billion over 5 years). It was also agreed that a National Health Council would be established by May 5, 2003, to "monitor and make annual public reports on the implementation of the accord, particularly its accountability and transparency provisions". The F/P/T First Ministers charged Health Ministers with establishing this Council and you carry that accountability.

You have now announced that the creation of a Council is now to be delayed till the end of May because of the SARS crisis. Although you assure us that the establishment of a Council is proceeding well, there is a growing concern in the health policy world that this is far from the case.

Disquieting rumours emanating from closed-door discussions by F/P/T "officials" include that the National Health Council is to "sunset" in five years – to be a temporary body only. We hear that it is to have no capacity of independence. That it will be entirely dependent on existing provincial/territorial and federal bureaucracies for data and information and that its reports to the public will be under the aegis of the F/P/T Ministers or Deputy Ministers of Health.

If true, why bother? As Mr. Romanow pointed out, the machinery of intergovernmental relations is cumbersome now, made so in part by a "dizzying array" of behind-the-scenes groups and other bodies. Do we need yet another?

The Health Council recommended by Mr. Romanow was not to be simply another body in this bewildering web of committees and expert panels. It was intended to be "a new way of doing business", reporting openly each year to Canadians on how well our health care system performs across the country. In short, the vision for a National Council is that it will provide better leadership and more direct accountability for the well over \$100 billion we spend each year publicly (about 70% of the total) and out-of-pocket for health care.

We fear the National Health Council about which we will hear shortly may be a very pale shadow of those conceived by Mr. Romanow and by the Senate Committee. And as such there is the very real risk that the new billions being poured into health care will do nothing more than shore up the status quo and will not, as Mr Romanow pleaded, result in real change to the system. Of course, nobody wants yet another ineffectual Committee cluttering up government decision-making. We don't need a 'new bureaucracy' but an 'anti bureaucracy', a body capable of cutting through the cloud of political obscurantism which surrounds our federal provincial transfers on health care these days.

A group of experts and opinion leaders met at the University of Toronto in mid-March to provide advice on how to make the National Health Council as effective as possible. The strong consensus was that it was essential that the Council be made of widely respected individuals, known for their personal integrity, selected on the basis of their knowledge, expertise, and experience and not because they represented any profession or constituency, who would contribute to the public perception of the Council as a body genuinely at arms-length from governments and their bureaucracies. It was considered vital that the Council be seen to be a) as independent as possible within the limits of the reporting relationship to the F/P/T Ministers of Health decreed by the First Ministers and b) that its processes be open and transparent; and c) that it have the capacity to obtain information from all sources and an in-house research capacity.

Delaying the establishment of the Council till the end of May could be a blessing in disguise. There may be time now to ensure that any Health Council created is more than a toothless tabby. Federal, Provincial and Territorial First Ministers promised Canadians in February an opportunity provide them with a voice in the governance of health care through establishing a National Health Council. All of us concerned with the preservation and enhancement of health care in Canada ask you to ensure that this opportunity to create a real and effective National Health Council not be lost. ♦

Colleen Flood, Faculty of Law, University of Toronto
Duncan Sinclair, Emeritus Professor, Queen's University
Terrence Sullivan, President Cancer Care Ontario

Charles Pascal, Executive Director, Atkinson Foundation, and former Ontario Deputy Minister

And many other Canadians

cc. all First Ministers

SOLUTION TO FEDERAL-PROVINCIAL BICKERING OVER HEALTH

Alberta Premier Ralph Klein and his health minister, Gary Mar, are frightened of the truth. That is why they are trying to kill the idea of an independent body of experts to monitor Canada's health care system.

From 1995 to 2002, federal and provincial politicians betrayed the Canadian principles of universal high quality health care. In 1995, the federal government hid huge cuts in health care funding to provinces by rolling transfers for health, education and welfare into a single Canadian Health and Social Transfer.

The cuts led to a dramatic reduction in public health care funding. By 2000, deficit hysteria was passing. Instead of rescuing the health care system, federal and provincial politicians made tax cuts their top priority. Then, they engaged in what Health Commissioner Roy Romanow called "corrosive and unproductive long-distance hollering and finger-pointing."

"The health system is falling apart because of lack of federal money," said the provinces. "The health system is falling apart because provinces are wasting federal money," said Ottawa.

Meanwhile, governments helped promote a big lie. They suggested that health care spending was out of control, there wasn't enough public money, and we had to make Canadians pay privately. Roy Romanow cut through the deception and confusion.

First, he listened to Canadian values. Shared security in a high-quality health care system remains a top priority of ordinary Canadians.

Second, he recognized that, as a percentage of GDP, Canada is spending less than a decade ago. Romanow noted that provincial and federal governments were losing over \$40 billion in income each year because of tax cuts. He saw

the large surplus the federal government was generating despite tax cuts. Romanow concluded that if we want to make it a priority, we have plenty of money for health care.

Third, he looked at the evidence. He saw that single-payer public health care financing is both efficient and equitable. And that investor-owned private for-profit health care delivery threatens our health.

So, he recommended much more federal money for health care. The money would be used to create big changes, including a move toward national home care and prescription drug (pharmacare) programs, and a reformed system of front-line care.

On February 3, 2003, federal and provincial governments agreed to put Romanow into action. But their accord left a major gap. The provinces could still use new federal money for tax cuts rather than improving health care. The money they did spend on health could be used to shore up the old system instead of, as intended, creating real change.

Romanow foresaw this problem of accountability, and his recommendations included a national Health Council including public representatives, academic experts in health care, and experienced health care managers.

The 2003 federal-provincial accord included a Romanow-style Canadian Health Council to be put in place by May 5.

May 5? Now it's the middle of June, and still no Health Council. Why?

Romanow saw that the Health Council would be a way of dealing with political bickering. The public would have a trustworthy guardian of the health care system who would tell them who is doing the job, and who is not. If the provinces, or Ottawa, weren't true to the

accord, the Council would let Canadians know.

Romanow also saw that, to succeed in highlighting government misrepresentations, the Council must include experts and public representatives.

Misrepresentations such as claims that there is a shortage of public money for health care, a need for a private pay system, and that investor-owned private for-profit health care delivery is more efficient. Ralph Klein and Gary Mar also realize that an independent Council will expose their political games.

That is why they want to kill the Council. These Alberta leaders have no commitment to carrying through Romanow's principles. They have no commitment to national programs of publicly funded home care and pharmacare, and they want to see expansion of investor-owned for-profit health care provision.

So they want a Council made up of government representatives rather than an independent body. Clearly, that would destroy its credibility and usefulness as an independent watchdog. Filled with federal and provincial government representatives, the council would be another forum for bickering.

Klein and Mar want a sunset clause for the council, which would last only the five years of the current accord. They want a miniscule \$2 million budget, instead of the proposed \$20 million that would allow the council to fulfill a wider mandate.

The overlapping health responsibilities of the federal and provincial governments have created an unworkable situation.

(continued on page 15)

SOLUTION TO FEDERAL-PROVINCIAL BICKERING OVER HEALTH (continued)

An independent national Health Council represents a desperately needed solution. In his phase of born-again Prime Minister doing what is best for the country, Jean Chrétien may override

provincial objections and create an independent health council. If he doesn't, health care will remain in big trouble. ♦

First appeared June 13, 2003 under the title of Independent Health Council is Best for Canada, as one

of Dr. Guyatt's twice monthly columns in the Hamilton Spectator.)

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

Name

Address

City

Prov/Postal Code

Telephone

Fax

E-mail

Membership fees:

Supporting member	Over \$195
Physician	\$195*
Affiliate (out of province) physician`	\$ 50*
Intern/Resident/Retired/Part-time	\$ 50*
Organization	\$ 50
Associate Member	\$ 50
Medical Student	\$ 25
Newsletter Subscriber	\$ 50

Please return to:

Medical Reform Group
Box 40074
Toronto, ON M6B 4K4

Areas of Expertise

Areas of Interest

I can be called on to assist with

Present Position

Membership Category

Fee enclosed Donation

Please charge my MASTERCARD/VISA in the amount of \$. My MASTERCARD/VISA Account number is

Name of Accountholder

Expiry Date

All categories of membership include a subscription to the MRG newsletter **Medical Reform**.
 * Physicians in other provinces may become Affiliate members. Non-physicians may become Associates.

If you prefer, you may pay your membership fees and supporting contributions through our monthly payment option by completing the following authorization and **enclosing a blank cheque, marked "VOID" from your appropriate chequing account**.

I authorize my financial institution to make the following electronic payments directly from my account:
 The amount of \$ on the first day of each month, beginning , 20 . Please credit the payments to the METRO Credit Union account (No. 1148590) of The Medical Reform Group.

I understand that these electronic payments will continue until I give notice in writing to the Payee to stop doing so; that I must notify the Payee in writing of any changes to the information in the authorization; and that I must notify the Payee within 90 days of any error in the electronic payment.

Account holder's name (Please Print)

Account holder's signature

Date

MRG CALLS ON PREMIER EVES TO ESTABLISH INDEPENDENT COMMISSION OF INQUIRY

June 9, 2003.

The Hon. Ernie Eves
Premier of Ontario
Queen's Park
Toronto M7A 1A7

Dear Premier:

The Medical Reform Group calls on you to establish an independent Commission of Inquiry under the Public Inquiries Act into the SARS crisis at your very earliest opportunity.

We must learn from our experience and it is critical that we listen carefully to health care providers, patients and families, including the health care professionals whose health and well-being have been compromised across all sectors of the health care system. We are especially concerned that our health-care system had difficulty handling the challenges presented by SARS, and we think an independent and broad-based investigation is necessary to product the kind of comprehensive recommendations we expect are needed to strengthen our health care system and ensure the health and safety of health-care providers and all Ontarians.

It is imperative that we examine the structures, policies, procedures and practices of government, health care organizations and health care providers which may have limited the effectiveness and timeliness of the health-care system's ability to respond to SARS. Moreover, we think the inquiry must examine the systemic barriers, including the lack of response to early warnings raised by nurses and others, which may have limited the effectiveness and timeliness of the health care system's ability to respond to SARS. Without a full independent commission of inquiry, there are no guarantees that health-care professionals will be encouraged to speak openly and that their jobs will be protected. ♦

**Medical Reform Group
Box 40074
RPO Marlee
Toronto, Ontario
M6B 4K4**

*Please visit and comment on our web-site
at <http://www.hwcen.org/link/mrg>
Please also make a note of our current telephone
(416) 787-5246; fax (416) 782-9054; e-mail: mrg@web.ca*