

MEDICAL REFORM

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HEALTH AND HUMAN RIGHTS

Ahmed Bayoumi shared speaking notes for a recent presentation

I am going to tell you three stories – one fictional, one historical, and one close to home. In a sense, they are all the same story, and it's a never-ending one.

The first story is the fictional one. It's the story of a river that runs through a peaceful, happy village. The villagers value their river for its sustenance. One morning, one of the villagers runs screaming through the town, calling the other citizens to come and help, for he has seen an infant floating in the river. The villagers run to the rivers banks. To their horror, they see not one infant, but several, floating away.

Without regard for their safety, they wade into the water to save the babies from floating further downstream, where a waterfall lies. Some villagers are hurt during the rescue effort. Others drown or are caught in the currents of the river and die. Many babies are saved, but some drown. But each day, more babies appear floating down the river and many villagers apply great efforts to save them.

Over time, however, the image of the babies in the river ceases to shock some villagers, who learn how to walk along the river's banks without being disturbed by the sight of innocent infants. And yet, none of the villagers ventures upstream to find out why there are babies floating in the water. If they did, they would find that this is not an accident of nature or a freak occurrence. Instead, it is the deliberate policy of a city upstream

who are discarding their superfluous citizens in the name of efficiency.

This story is, of course, an analogy for much of what I am going to discuss about health and human rights. Perhaps the most important point this story makes is to remind us of the importance of looking for upstream causes for the injustices around us. Too often, both activists and academics, focus on identifying the injustice or ameliorating its consequences while neglecting the structural causes that lead to these inequities. Academic health researchers, in particular, do this distressingly often.

There are millions of dollars currently distributed in the United States for the study of health disparities – usually focusing on racial and ethnic differences in health and health outcomes. This is important work and it is vital to

continue to document inequities in the delivery of health services and in the attainment of health outcomes. But very little of this work questions how the very structure of society – the class, gender, and race relations – establish the conditions for becoming or staying healthy.

Even the dominant strain in Canadian public health research of the last couple of decades – the “determinants of health” approach to studying health – displays this tendency. The inclination of public health researchers has been to develop a list of items that are associated with ill health. Health Canada lists 12 “key determinants” including income and social status, social support networks, education and literacy, gender, culture, use of health services, and so on.

Again, this is important work – it often illustrates quite vividly how poverty, for example, is inextricably connected to ill health. Only 47 per cent of Canadians in the lowest income level rate their health as excellent or very good, compared to 73 per cent of Canadians in the highest income group. Yet what we still lack, is any comprehensive understanding of how such determinants fit together, what it is about income inequalities that leads to full health, and, perhaps most importantly, which policy changes – or structural changes – are necessary to address these discrepancies. Rarely will academics in health faculties raise the question of how capitalism or globalization influences health. It's as if asking such questions is

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Medical Reform

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

Editorial committee this issue: Rosana Pellizzari, Janet Maher.

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

1. Health Care is a Right.

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

2. Health is political and social in nature.

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

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

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

viewed by the mainstream majority as either too radical or too irrelevant; as if venturing beyond the world of epidemiology, with its emphasis on empiricism and documentation, is taboo.

To go back to the story of the babies in the river, much academic health research is focused on counting the number of babies in the water. And the research that does look upstream, for the most part, either doesn't look far enough up the river or looks only at certain spots, without making the full connections, establishing the necessary links.

Apart from the imperative of looking for structural causes of ill health, there are two additional aspects of this story that I find particularly appealing. First, remember the nobility of the villagers rescuing the babies. I do not mean to imply that the necessity of focusing on upstream causes in any way detracts from the imperative of helping those in need. Neither academic studies nor activist polemics are a salve for individuals suffering the health consequences of social injustice. Similarly, the "determinants of health" approach to studying why people become ill too often under-emphasizes the importance of health service delivery to people who are sick.

The second reason that this story appeals to me is because of the religious allusions it contains. This is not at all because I want to argue for a "faith-based" approach to addressing these problems like George W. Bush might, but rather because I want to argue that the role of values is essential in determining how we define justice and equity. While the answers to questions of ill health are not to be found in the technocratic, numeric solutions of the bean counters, neither are they to be found in an elusive essentialist conception of fairness. The definition of what constitutes fairness or justice or equity becomes a political act to be contested and argued based on values and principles.

I will discuss how this relates to the concept of human rights, but first let me first tell you my second story. Almost 150 years ago, John Snow removed a water pump handle in London to stop the spread of cholera. Academic folklore hails this act as the birth of public health. To recount the events of 1854 briefly: London was in the midst of its 4th major cholera epidemic since the disease arrived in Britain 23 years earlier; these epidemics had claimed over 100,000 lives.

The prevailing "miasma" theory held that cholera was not contagious but rather spread from the foul air emanating from decaying organic material. In 1849, an anesthiologist named John Snow published a treatise supporting the "germ theory" of cholera and implicated contaminated water as the means of spreading such an organism. His work did not receive widespread recognition until the 1854 outbreak, when Snow showed a strong and convincing association between cholera and one of London's two water companies.

In one Soho neighbourhood, 500 people had died in 10 days. Snow made painstaking studies and identified a pump on Broad Street as the likely source of the epidemic. Snow took his data to the Board of Guardians of St James's Parish; although they remained sceptical, they agreed to remove the pump handle as an experiment. Enthusiasts have hailed this event as an early example of epidemiologic field work and the use of mapping techniques, an example of the value of deductive hypothesis testing as an epistemological method, and an affirmation of biologically grounded germ theory over the ill-defined "miasma" alternative. Each of these readings is accurate in its way, yet each also misses instructive elements which still resonate today for those interested in health and human rights.

The first point, as above, is about the importance of looking for underlying

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HEALTH AND HUMAN RIGHTS (continued)

causes. Moving literally upstream from the pump, the incident at Broad Street can be viewed as the result of a specifically social condition, the use of cesspools.

How did cholera contaminate the Broad Street pump? The parents of a child who subsequently died with diarrhea had washed his diapers. The soiled water drained to a leaking cesspool close to the pump, which was the likely source of contamination. But why did the cesspool leak? There were over 200,000 cesspools in 19th century London; the human manure from these cesspools was sold to farms surrounding London for fertilizer. Yes, there was a market for human waste. Sometimes, capitalism's capacity for innovation truly is amazing!

The city of London's rapid expansion likely contributed to the spread of cholera since the increasing distance between city and country made cesspool fecal material prohibitively expensive. The resultant loss of income diminished available funds for cesspool maintenance, which fell into disrepair. Although this link between a specific social condition – urbanization and the advent of the market economy on the one side; ill health on the other – was recognized at the time, the call of social reformers for cesspool removal went largely unheeded.

Then, as now, such social conditions took place within the context of globalization. In 1847, importers started selling guano from South America at prices below that of human manure, further diminishing revenues for cesspool maintenance. Furthermore, cholera itself was an “imported disease”; the late 19th century pandemics tended to start in India and were spread by soldiers, merchant shipping and other commercial ventures, and religious pilgrims, particularly Muslims making pilgrimages to Mecca. Indeed, a common adjective applied to cholera at the time was “Asiatic.”

Lastly, although Snow has been lauded widely, a more nuanced exploration of John Snow's motives and methods is useful. Recall that a major challenge for Snow's research was to convince policy makers of the importance of his findings. Indeed, many remained sceptical, even as the cholera epidemic abated. A few months after the pump handle removal, the London Board of Health reviewed and summarily dismissed Snow's “suggestions.” That Snow remained engaged in the political processes is a credit to him but also a reflection of the roles which publicly minded physicians created for themselves.

Yet the rigor of Snow's work has been called into question. Indeed, his report on the Broad Street pump has elements more redolent of a polemic than a scientific assessment. Snow may well have been out to prove a point – his earlier advocacy of germ theory – rather than test a hypothesis.

And his motives may also be called into question because of other activities. A year later, Snow testified to the Board of Health on behalf of manufacturers whose processes emitted noxious fumes, a defence for which he was roundly criticized by the *Lancet*. The tenacity with which he clung to his views and his willingness to attack alternative viewpoints with little empirical proof are salient reminders that much of what is presented as objective research can be conflated with other purposes.

To return then, to the concept of human rights in health. The appeal of the concept of human rights, of course, lies in their “equal and inalienable” nature. But, as commonly conceptualized, the concept of human rights has limitations, of which three come to mind.

First, is the issue of comprehensiveness. This is the idea that all rights that are important have been identified and codified. Such an approach has the unappealing stench of triumphalism; it will, invariably, support the status quo

condition. If we are to think more broadly about what constitutes human rights – what things individuals cannot be justly denied – we might look much more critically at what makes individuals healthy or sick.

What does it mean that the International Covenant on Economic, Social And Cultural Rights, adopted by the U.N. General Assembly in 1996, guarantees the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health”? It clearly means the things most people take it to mean – avoidance of discrimination or health policies that violate rights, freedom from torture, and so on. But does it mean more? Does it extend to the way societies are built?

The second limitation of the current approach to human rights lies in the way in which these rights are interpreted or actualized. In the 1980s, the United States Supreme Court ruled that there is no right to health care. Congressman Jesse Jackson Junior has introduced a constitutional amendment to enshrine the right to health. This is a good thing, but I would say that Al Sharpton is wrong when he states that “the advantages of fighting for human rights and constitutional amendments is that human rights and constitutional amendments are non-partisan (they're neither Democratic nor Republican), they're non-ideological (they're not liberal, moderate, or conservative), and they're non-programmatic (they don't require a particular means, approach or program to realize them). They're also not a “special interest.” The struggle for rights is intensely political, as is their interpretation.

Which is the final limitation of the human rights paradigm. We tend now to define human rights, and violations thereof, in narrow legal terms. Just as health is not the sole domain of doctors, neither can human rights be the sole domain of lawyers.

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HEALTH AND HUMAN RIGHTS (continued)

Let me end with the final story, that of one of my patients whom I will call Lily. Lily immigrated from a Caribbean island to Canada as a young adult several years ago. Here she met and married a man from Africa. When she was pregnant with her first child, she was counselled to have an HIV test, to which she consented. To her surprise, it came back positive.

Lily has less than a high school education and has a hard time understanding all of the details about her HIV infection, but she knew that she had to take her medicine so that her baby would have a chance of being HIV negative. Indeed, she gave birth to a healthy, HIV negative baby boy.

But her troubles were not over. Lily has worked in low paying jobs, without drug insurance. To apply for catastrophic drug assistance – the Trillium drug program – Lily needs to declare her total household income.

But although she lives in the same house as her husband still, he has stopped talking to her since he found out that she was HIV positive. They lead strangely separate but parallel lives, living in the same house but barely communicating. After much work with our social worker, Lily was able to get the bureaucrats to

exempt her from reporting her husband's income last year so that she could pay for her HIV medications. But she needs to apply again.

Lily has a hard time keeping her appointments, even though I see her outside of my usual clinic hours. She lives and works far away, but doesn't want to leave our clinic because she feels safe and supported there. She also has poorly controlled diabetes. She has told nobody, besides her estranged husband, about her HIV status. At times, she becomes very depressed and anxious. In truth, I am unsure what will become of Lily.

Think about how globalization and capitalism have affected Lily. Most immediately obvious is the global spread of HIV infection. But one could also ask why Lily's education was so poor that she has fundamental literacy problems. One could ask what patriarchal structures operate to keep her in a housing environment where she is treated inhumanely. One could ask what economic policies keep her in meagre jobs. One could ask what barriers prevent her from controlling her blood sugar effectively or keeping her clinic appointments. One could ask what political structures allow a "catastrophic" disease rescue drug program to be a

politically acceptable substitute for a truly universal drug program. In short, one could ask if Lily will keep falling through the cracks, and why.

And one could worry about Lily's beautiful young son. One could go back and reread the Universal Declaration of Human Rights and ask whether Article 25 is being met, which states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services" or Article 26 that states "Motherhood and childhood are entitled to special care and assistance."

We do what we can to help Lily, but it is also necessary to interrogate these concepts of human rights critically and even more so, to hold governments to the standards they have agreed to – politically as well as legally. It is easy to become overwhelmed by the enormity of the problems, but as the great political theorist Antonio Gramsci famously said, "It is necessary to direct one's attention violently towards the present as it is, if one wishes to transform it. Pessimism of the intellect, optimism of the spirit."

A QUESTION OF PRIORITIES

Member Shelly Sender forwarded this letter on a talk by the Head of US Centers for Disease Control, published by the Hamilton Spectator March 1, 2004.

Dr. Gerberding in her talk yesterday extolled the gleaming new quarters of the CDC and their high tech "comand post" for monitoring emerging diseases. The implication was that this is a public health model that Canada should emulate and indeed it appears that McMaster is anxious to do so.

Unfortunately Dr. Gerberding's talk failed to mention that the U.S. actually

lags behind Canada and the rest of the industrialized world by most measures of public health success, such as infant mortality or life expectancy. Far more people in the U.S die from inadequate health care than from bioterrorism or imported diseases.

Glitz is not all. Canada has much to teach our southern neighbors when it comes to public health and it is a shame

that this was not mentioned in your article or in the talk.

Sincerely,
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HEALTH-CARE WAIT IS WORTH IT

Canadians are upset about waiting times for health care. Perhaps their distress would diminish if they realized that substantial waits for service are a necessary and valuable part of any health-care system.

Why does efficient health care rely on making patients wait? Much of health care is discretionary. In other words, while the patient might like to receive the service, and the doctor might like to provide it, the service might not improve the patient's health.

What would happen if each of us ran to the doctor with every minor snuffle, or every new ache? Some might appreciate the reassurance that their problem isn't serious, but the cost in terms of health-care expenses and lost productivity would be enormous.

What if doctors ordered sophisticated tests such as MRI or CT for any headache with a one in 10,000 chance of a brain tumour? What if physicians ordered heart catheterizations that involve injecting dye into the arteries of the heart for every chest pain that might remotely be related to the heart?

High technology tests carry obvious burdens of expense and inconvenience and, for tests such as heart catheterizations, small risks of serious adverse events such as heart attacks or strokes.

No test is perfect, so testing also carries hidden risks. Abnormal results that require further testing, or even surgical procedures, may turn out to be either incorrect or irrelevant.

The large volume of discretionary activity — probably most of what doctors do — emphasizes that medical care is potentially a bottomless pit that could consume a huge chunk of our national wealth. Thus, the need for rationing.

So, how should we ration? We could restrict access to health services by ability to pay. That would be unfair and

inefficient. The discretionary nature of medical care tells us that some people paying to get to the front of the queue wouldn't benefit from the services they receive while those pushed back may be poor and needy.

We could develop a series of rules, and have auditors make sure doctors stick to the rules. That would create an administrative burden, with resources going to monitoring instead of patient care.

These two strategies are popular in the U.S., which helps explain why their system is disastrously inefficient. In Canada, we ration largely by limiting availability. We have only so many hospital beds, operating rooms, and MRI and CT scanners.

This leaves doctors to decide which patients need care the most. Whether in the emergency room or the testing wait list, the patients who most urgently need the service jump to the head of the queue, and the rest of us wait.

In general, this rationing by need works well. But, in a number of areas, Canadians feel they are waiting too long. There are, however, several reasons we should be cautious about assuming the waiting lists themselves — rather than Canadians' perceptions about waiting lists — are a serious problem.

First, we have little reliable information about waiting lists. The Fraser Institute, a right-wing lobby group, releases much-publicized waiting time information each year. Based on unreliable reports from physicians, with a very poor response rate to their surveys, the Fraser statistics are not trustworthy.

When researchers do look carefully at waiting lists, surprises emerge. While a 1997 poll found that two-thirds of Canadians believed waiting lists were increasing, a formal study of wait-times for eight elective surgical procedures in Manitoba found that, between 1991 and

1996, wait times actually remained the same or decreased.

Second, just because you are on a waiting list doesn't mean you really need care. Audits of waiting lists in Britain and New Zealand have found that between 25 per cent and 50 per cent of patients on surgical waiting lists either don't warrant the procedure, or turn it down when finally offered a chance at surgery. The new Canada Health Council has set one of its goals to produce accurate waiting time information — ideally including documentation of need. Hopefully, the council will be up to this very large challenge.

Third, British experience indicates that if we open up more emergency room beds, train more specialists, purchase more MRI and CT machines, or open up more operating rooms, waiting lists may well not decrease. The reason is, once again, the discretionary nature of care. When waits are long, doctors don't refer patients who may not need the test or procedure. As patients and doctors hear of shorter waits, these borderline patients start appearing on waiting lists, which once again fill up.

It is likely that there are areas of Canada in which certain patients — possibly those with cancer, heart disease, or needing elective surgery — wait too long. But the complexities of the waiting list issue suggest careful study and planning before we try to solve a problem that may be much smaller than we imagine.

First published March 16, 2004 as one of Dr. Gordon Guyatt's biweekly columns in the Winnipeg Free Press.

INTERVENING ON ONTARIO BILL 8

The Medical Reform Group has been monitoring closely the performance of the new Ontario government, including Irfan Dhalla's letter of March 22, 2004 to the Hon. George Smitherman, Minister of Health and Long Term Care, and following, a brief presented by Aaron Rostas and Brad MacIntosh to the Standing Committee hearings on February 23, 2004.

Thank you for your letter of March 17th in which you outline Bill 8 amendments approved by the Standing Committee since the committee hearings.

As our representatives indicated at the hearing on February 23rd, we are very concerned that in its zeal to protect public health care in Ontario, your government does not end up undermining existing structures Ontarians have come to depend on.

While we welcome several of the amendments as more or less consistent with other legislation and administrative principles, and we look forward to active participation in the development of companion regulations for all parts of the bill, we were very disappointed your approach to block fees appears to shift the debate from whether such fees should be allowed to how much could be charged.

Block fees are becoming more common and more expensive. A recent article in the Hamilton Spectator described a physician in Ontario who will be charging each of her patients \$267.50 per year. Such a block fee would violate the College of Physicians and Surgeons of Ontario's policy (which states that block fees must be optional), and illustrates that the CPSO is not effectively regulating block fees. This physician is also described as aiming for a practice of just 380 patients. With the extra \$100,000 she will receive from block fees, she would obviously be able to afford a small "boutique" practice. But what of all the patients she dismisses from her practice? Where will they go for primary care?

We therefore urge you specifically to reconsider the issue of block fees as currently set out in your Bill and to prohibit them entirely and categorically.

As citizens, we would also like to take this opportunity to recommend the considerable virtue of making accountability agreements public, consistent of course, with appropriate privacy protections for both providers and users of health care in Ontario.

BRIEF TO THE STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY ON BILL 8: COMMITMENT TO THE FUTURE OF MEDICARE ACT

The Medical Reform Group of Ontario (MRG), formed in 1979, is a group of approximately 300 practising physicians and medical students. The MRG represents the views of its members on health and health care matters through research, public statements and consultation with other groups who share our aim of maintaining a high quality publicly funded, universal health care system.

The MRG believes that health is political and social as well as medical in nature and that health care is a right. The Medical Reform Group of Ontario is pleased to be able to appear before the Standing Committee on Justice and Social Policy on the matter of Bill 8, also referred to as the Commitment to the Future of Medicare Act.

We are pleased that the government is explicitly stating its support for Medicare in Bill 8. Our presentation today will focus on areas where we believe Bill 8 can be strengthened to ensure that Ontarians receive the best health care possible.

Our brief will discuss Parts I, II, III, and V of Bill 8. For each section, we will first present an MRG Synopsis, then an MRG Position, followed by an MRG Analysis and/or Recommendations.

Preamble

MRG Synopsis

- ◆ Commits the government to the five principles of the Canada Health Act.
- ◆ Recognizes that pharmacare (for catastrophic drug costs) and

homecare based on need are important to the future of the health care system.

- ◆ Recognizes that access to primary health care is a cornerstone of an effective health system.

MRG Analysis

The Medical Reform Group is encouraged that Bill 8 recapitulates the values endorsed by the Romanow commission, but noted that a disconnect exists between the language of the preamble and the implementation articulated. The MRG views Bill 8 only as a partial support for the prohibition of two-tier medicine, extra-billing and user fees.

INTERVENING ON ONTARIO BILL 8 (continued)

Part I—Ontario Health Quality Council

MRG Synopsis

- ◆ Government pledges to establish a council that would, at minimum, deliver an annual report on access to publicly funded health services, health human resources in publicly funded health services, consumer and population health status and health system outcomes.
- ◆ The council would have 9 to 12 members, appointed by the Lieutenant Governor in Council.
- ◆ The Council could only make recommendations with regard to future reporting needs.
- ◆ Funding, governance, regulations regarding specific powers, etc. would be determined by the Lieutenant Governor in Council.

MRG Analysis

- ◆ The Medical Reform Group strongly supports the development of a council to report back to Ontarians on the state of their health-care system.
- ◆ We agree with the proposed size and support the notion of diversity among Council members.
- ◆ We believe the appointment process, as structured, could potentially lead to the formation of a partisan council that is not sufficiently independent from the government.
- ◆ We suggest instead two alternative approaches for appointing members:
Option 1: The council could recommend its own replacements; these replacements could then be individually approved or rejected by a vote of the legislature. The political parties, in proportion to their representation in the legislature, could appoint members of the first council. This approach would limit partisan appointments and ensure that each council member had broad support within the health care community.

Option 2: During each provincial election, the various provincial parties could submit a short list of nominees (each of whom would fulfill pre-specified criteria regarding health-care expertise). Ontarians could elect three or four council members at the time of each provincial election. In a manner analogous to school board elections, we believe this would increase citizen participation and interest in health policy.

- ◆ We also strongly recommend that the council's power to make recommendations not be limited to reporting needs.

The Ontario Health Quality Council would be well placed to make non-partisan recommendations regarding health care system structure and function. For political reasons, government must often focus on short-term goals. Short-term cost-containment often wins out over long-term cost-effectiveness. A council with sufficient power and independence could make longer-term recommendations that would increase the effectiveness and efficiency of Ontario's health care system.

Part II—Health Services Accessibility

MRG Synopsis

- ◆ This section of the bill prohibits designated practitioners (e.g., physicians) from accepting money from patients for insured services.
- ◆ The government prohibits extra fees for preferential access to insured services.
- ◆ Block fees are permitted for “necessary adjuncts” only where:
 - o Insured services continue to be offered to those who elect not to pay the block fee.
 - o Regulations regarding the circumstances under which block fees may be levied are followed.

(These regulations are to be defined by the Lieutenant Governor in Council.)

- o Individuals violating the block fees provision can be fined up to \$25,000 or imprisoned for up to 12 months, or both, for a first offence

MRG Analysis

- ◆ The MRG strongly supports the notion that health care practitioners be permitted to charge OHIP only for insured services.
- ◆ The MRG strongly supports the right of the government to regulate block fees for non-insured services. However, we believe that the government should go beyond regulating block fees to ban them entirely.

Recent news reports have highlighted instances where doctors have circumvented the College of Physicians and Surgeons of Ontario's Block Fees Policy. For example, the *Globe and Mail* recently reported that two doctors are charging their patients \$2500 per year to receive care. This practice, reasonably common in the United States, is known as “boutique medicine” and has come under intense criticism across the border.

The CPSO's own publication reported that patients in one Ontario town were told that their doctor's office would not return telephone calls unless they paid a block fee. There are several important reasons why block fees should be banned:

- o With thousands of Ontarians unable to find a family doctor, it is irresponsible and unethical for physicians to limit their practices to a few affluent patients who are willing to pay fees for medically unnecessary care. Furthermore, the number of physicians per 100,000 Canadians (187 physicians per 100,000 Canadians in 2000, CIHI)

INTERVENING ON ONTARIO BILL 8 (continued)

is significantly lower than all G7 countries except U.K. and Japan . Due to the financial incentives, block fees discourage from taking on new patients. According to the CIHI, Ontario has the lowest number of family doctors per capita of any provinces.

- o Many of the items for which some physicians charge fees are in fact medically necessary. What are called “necessary adjuncts” in Bill 8 are essential to the doctor-patient relationship and should in fact be insured services. These include such responsibilities as acting as a patient advocate, giving customized advice, renewing prescriptions and providing adequate transfer of care when a patient needs a new doctor.

- o Any block fee will inevitably open the door to some form of boutique medicine. Non-paying patients may receive less of the doctor’s time at appointments or less advocacy when they need an important diagnostic test.

- o Due to difficulty monitoring block fees, as well as the natural reluctance of patients to complain about their doctor, a block fees policy designed to minimize harm is unlikely to be successful.

- ◆ If block fees are to be allowed, the government should still ensure that “necessary adjuncts” (as defined by either the Lieutenant-Governor in Council or the Ontario Health Quality Council) be excluded. Block fees should include only truly optional services (e.g., forms for summer camp, non-insured vaccinations, travel medicine appointments, etc.)

Other recommendations to minimize harm include:

- o Doctors who charge patients block fees should be required to post a government-designed poster in their office outlining what services cannot be included in the fee. The poster

should also explain to patients how they could file a complaint if their doctor is violating the policy.

- o Government should clearly state that doctors must not discriminate between patients who pay a block fee and patients who do not, neither in terms of accepting them into their practice nor in terms of the quality of OHIP-covered care that is provided.

- o Government should permit itself the right to specify a maximum allowable block fee.

Part III—Accountability

MRG Synopsis

- ◆ The government can direct health care providers to enter into accountability agreements with the minister. Accountability agreements would establish performance goals and objectives and ensure “consistency” and “value for money.”

- ◆ The government can issue “directives” compelling health care providers from taking, or refraining to take, any particular action

- ◆ Disclosure of “accountability agreements” is at the discretion of the Minister.

MRG Analysis and Recommendations

The MRG strongly supports the notion of accountability in health care, including the ideals of “consistency” and “value for money.” The current draft of the bill, however, appears to give government all-encompassing power over health-care providers. We feel that the bill needs to be clarified to better define the scope of government power.

The MRG feels it is important to point out that efforts to increase accountability for health care providers in this Act is occurring in parallel with new Hospital mortgage financing schemes, so called P3 hospitals. This will create an environment that legitimizes the transfer of Hospital administration

ownership from public hands to private for-profit entities.

MRG members have been centrally involved in peer-reviewed systematic research on outcomes in for profit and not for profit health care facilities, and testified at length to the Romanow Commission on the Future of Health Care in Canada. There is no evidence that for-profit facilities will improve health outcomes or reduce costs and considerable evidence to the contrary.

The MRG is concerned that disclosure is at the discretion of the Minister. This inevitably would lead to “secret” agreements between government and health care providers. We recommend that Bill 8 be modified to ensure that all accountability agreements be made publicly available, thereby ensuring transparency.

Key recommendations:

- ◆ To ensure a politically diverse council that is independent from government, the MRG recommends that the appointment process for the Ontario Health Quality Council be modified.

- ◆ To ensure that the Ontario Health Quality Council has real influence, the MRG recommends that the mandate for the Ontario Health Quality Council be expanded. Specifically, the MRG recommends that the council be encouraged to make evidence-based recommendations on how Ontario’s health care system is structured and how services are provided.

- ◆ To ensure that all Ontarians have equal access to medically necessary care, the MRG recommends that the government ban block fees entirely.

- ◆ To ensure transparency, the MRG recommends that all accountability agreements be made public.



CENTRAL TORONTO

Community Health Centres



QUEEN WEST

Community Health Centre

CENTRAL TORONTO COMMUNITY HEALTH CENTRES Physician Permanent Full Time (Shout Clinic)

CTCHC is a non-profit, community-based health organization committed to improving the health of community members particularly those at risk for poverty and discrimination. Our multi-disciplinary approach includes the provision of primary health/dental care, counselling, harm reduction, community development, advocacy, and innovative partnerships with other organizations. CTCHC is a leader in the development of inner city health services: Shout Clinic focuses on the needs of homeless and street involved youth under 25; Queen West focuses on adults, families and youth in the local area. CTCHC is a pro-choice and gay positive organization committed to employment equity and anti-discrimination. Both our sites feature beautiful downtown facilities and Queen West is fully accessible.

Responsibilities

- o Provides comprehensive primary care (including on-call services) to homeless and street involved youth
- o Participates in a collaborative model of care with nurse practitioners, other staff and local organizations
- o Participates in broader activities of the Centre, e.g. planning, evaluation, advocacy, student supervision, workshops, research.

Qualifications:

- o CPSO registration, CCFP, certificate preferred
- o Experience in community medicine and multi-disciplinary team model
- o Desire to work with young people who are marginalised
- o Experience in HIV/AIDS care and/or mental health issues an asset

Salary: \$ 108,181 - 129,242 (inclusive of on call)

The successful candidate will demonstrate a willingness to participate in CTCHC's commitment to becoming a discrimination-free health centre and an ability to work interdependently and respectfully in a multi-disciplinary team.

Languages other than English are an asset.

Excellent benefit package including same-sex spousal benefits.

To better represent the communities we serve, applications from members of racial or cultural minority groups, Aboriginals, lesbians and gay men are encouraged.

Please apply by quoting Job #SH27 to:

**Hiring Committee, Central Toronto Community Health Centres
168 Bathurst Street, Toronto ON M5V 2R4 Fax 416-703-7832, e-mail: hiring@ctchc.com**

We wish to thank everyone for showing interest however, only candidates to be interviewed will be contacted.

MRG STUDENT CHAPTER IS BORN

Aaron Rostas

The grassroots of the Medical Reform Group grew from a base of mainly young physicians and medical students. At its inception in 1979, memberships belonged almost exclusively to residents and students.

Over the past 15 years, many of these individuals have gone on to have distinguished careers while maintaining the sense of social consciousness and activism that served as the foundation for forming the MRG. While over 90 per cent of current MRG members are practicing physicians, one can still find interspersed among the group younger student members who hold the same sense of idealism that caused the veteran members of the MRG to initially form the group.

In 2004 a new MRG Student Chapter at the University of Toronto hopes to further inspire and instill idealism and social health concerns amongst students and further fill the MRG with youthful faces.

In February 2003, I rode a bus to Toronto on my way to my admissions interview for medical school. In order to both ensure that my health knowledge was current and allay my nervousness through distraction, I held in front of me a summary of the Romanow Report on the Future of Healthcare. Unsurprisingly the topic of two-tier health care came up during the 'ethical' portion of the interview, and I gave an honest answer about health as a human right that should be conferred to not only all Canadians, but all of humanity.

Knowing that any prospective student given a similar question would likely have given a similar answer irrespective of their actual beliefs, I wondered if many medical students were genuinely concerned about upholding our compassionate health care system. A number of months later I happily discovered that indeed many medical students shared this sense of duty to speak out for those without a strong voice.

As any medical student can attest, the initial week of medical school is a mixture of partying and persuasion by student groups hoping to allure you into joining their cause. Well organized groups existed to push for funding for international aid efforts, choices in women's reproductive rights, and to help school children in less wealthy areas. Not sure which of these noble organizations most deserved my time, I delayed the decision; inevitably time passed and I remained uninvolved.

In mid-September, the MRG held a panel discussion on activism and advocacy in medicine given by three renowned speakers. In reading through MRG pamphlets, I recognized the absence of a group working towards social justice within the framework of medicine at U of T. After the talk, several first year students along with the second year social advocate Andrew Pinto mulled over the notion of a student chapter of the MRG. A similar conceit also formed among several students and residents already involved in the MRG and in late October, a number of students met to brainstorm on the direction of the new group. Shortly after a constitution was drafted

The Student Medical Reform Group (sMRG) at U of T currently has 10-15 active members who meet monthly. A further 120 students are subscribed to an email list and receive information and notice of events. The group acts autonomously from the professional group, though its constitution was drafted from the MRG doctrine. In addition, the co-chairs foster communications between the two groups by also attending MRG Steering Committee meetings.

Students are free to choose topics of interest. Akin to a Problem Based Learning model, students research a topic, and each meeting one or two students present their findings and allow for discussion of the topic. Areas of interest

have included private CT/MRI clinics, supervised injection sites, analysis of the American healthcare system, and others.

Response by students has been impressive, especially given that the group is still getting off the ground and began midyear after many students had already made commitments to other groups. Despite early success, many areas for improvement remain.

The group hopes to further branch out from medicine to include a greater number of students from other health related fields in an effort to be truly interdisciplinary and benefit from the different skills and perspective non-medical students bring. Further, the group aims to act as a resource for the professional group in conducting research and discovering new areas for the professional group to speak on. Finally, it is the hope that through contacts and friends at other medical schools across Canada, further student chapters will be established.

With the same sense of idealism and optimism that lead to the formation of the MRG, it is my hope that with the establishment of student chapters across Canada, a new generation of physicians and health professionals will engage in increased social and political health advocacy.

UNIVERSITY OF TORONTO TUITION FEE RALLY

Members Philip Berger and Ahmed Bayoumi spoke out at the February 4, 2004 Rally

Good afternoon. My name is Philip Berger and I am an Associate Professor in the Faculty of Medicine. I am here to oppose the exorbitantly high tuition fees for medical school and other professional faculties.

It has been the Faculty of Law, to its discredit, that has led the charge for higher tuition fees. The Law Faculty relied on an allegedly scientific study by the University's Provost, published on February 24, 2003. The Provost's study examined the question of whether raising Law School tuition fees would affect the proportion of low-income students entering Law School.

The Provost's study, though scientific in style and appearance, provides only an illusion of truth and reliability. In regard to accessibility and tuition fee increases, the Provost in her study asked the wrong research question. Rather than trying to determine if the proportion of low income students has declined as tuition fees have increased (and, as it happens, the proportion decreased by 20 per cent when fees increased from \$12,000 to \$14,000), the Provost should have asked why students from disadvantaged, poor and low income families are massively under-represented in Law School and why students from affluent and wealthy families are massively over-represented. No, the Provost's study is not a scientific document; it is a political and ideological document that is flawed to its core.

But on April 4, 2003, the Governing Council of the University of Toronto, relying shamelessly on the Provost's study, approved increases in tuition fees for Law School as it has done for Medicine and other professional faculties.

Rather than boast that "accessibility is being maintained for those from lower and middle income households" in Medicine and other professional faculties, the Provost and Governing Council should view the distribution of socio-economic background of these students as a mark of shame.

Does the Board of Governors – or does anybody – seriously believe that raising tuition fees will help correct the indefensible inequity in professional faculties?

The Governing Council, in approving increases in tuition fees for medical students and others, has moved further down the road of creating professional faculties staffed by professors of privilege who will be teaching students of privilege who upon graduating will have been trained to provide services to citizens of privilege.

The Council has guaranteed that the Law Faculty will be graduating lawyers whose class background will orient them more to corporate law than to legal aid clinics; that the University will be graduating doctors and dentists whose inclination will be more towards the wealthy who are generally healthier than the poor who actually need the services; and that the University will graduate architects and designers more oriented to the structure of private homes and offices rather than subsidized housing projects.

The University of Toronto Governing Council has failed in its duty to represent the interests of all citizens, no matter what their class and background. Instead it has expanded and entrenched elitism in professional faculties. The Provincial Government has a serious problem. A problem with punishing tuition fees and a problem with a Governing Council that does not represent the diversity and class background of the citizens of Toronto. The Provincial Government should initially freeze and then roll back tuition fees. And it should order the transformation of the Governing Council so that the Council itself represents the interests and ambitions of all citizens – not only the wealthy elite. Only then can we expect a legitimate and fair determination of reasonable tuition fees, a determination not based on the rich deciding for the poor.

Tuition fees are too high. The University of Toronto Governing Council may believe that they have set rates appropriately, but the truth is that there is no magic formula to calculate what the appropriate tuition fee should be. Instead, the tuition schedule reflects basic values about how we think about people, how we think about access to services, and how we value knowledge.

What do high tuition fees tell us about how the university thinks about people? Well the news is not very good. First, it tells us that we don't value all individuals equally. Students with more money face fewer obstacles when applying to professional schools than students from poorer backgrounds. This was always true, but it's more true now than ever.

This is the legacy of a government that Ontarians finally elected out of office last year after declaring that they had had enough of policies that provides access to people based on their socio-economic status. We don't want a university organized around those same principles.

The University of Toronto Provost issued a report last year evaluating the impact of tuition fee increases on law school admissions. The report says that applicants to law school haven't changed with respect to their social and economic background. But the report misses the mark by asking the wrong questions.

What we really should be asking is this: First, what's the correct comparison for assessing whether professional school enrollment from disadvantaged populations is where it should be? Comparing enrollment today to enrollment a few years ago seems to imply that there were no burdens to enrollment back then! Let's compare enrollment to what we think it should be, not to what it was when things were a little bit less unfair than they are now.

The second unanswered question is: Who is not even applying to professional schools because they know that their debt burden will be too high? That may be an

TUITION RALLY (CONTINUED)

unanswerable question – but I would bet that the threat of exorbitant tuitions has been a very effective deterrent for people who cannot fathom incurring mountains of debt.

High tuition fees also tell us how we value students and how we value access to care for the poor and disadvantaged. By burdening students with enormous debts, we place additional constraints on them. Some students' choices are certainly guided by their economic situations. The provost's report shows a trend over time for law students to work in large firms rather than in the kinds of places where public interest law is likely to be practiced.

The report says that the trends are not statistically significant, but this doesn't mean that the results are not real. More likely, the number of people studied are just too few. The university could be missing an important warning sign – one that it would rather not see anyway.

Lastly, very high tuitions tell us something about how education and knowledge are valued. It's not surprising that the last government, one of the most ideological governments in the history of this province, saw knowledge as yet another commodity to which the market should attach a value. But it is distressing that the Governing Council seems to have adopted this same philosophy. It's time to reassert the conviction – long a value of academics – that knowledge is not the sole domain of the rich and powerful, that universities, including professional schools, should be open and accessible, and that educational policies should be progressive and non-discriminatory – including against the poor. It's time for the new government to reassert a vision of social justice and equity in education. And it's time for Governing Council to rise to its role as guarantor of academic excellence and accessibility. A good start is by freezing tuition fees now. And a good next step is to start rolling back the increase.

Ahmed Bayoumi

PRESCRIPTION FOR EXCELLENCE: HOW INNOVATION IS SAVING CANADA'S HEALTH CARE SYSTEM

Michael Rachlis sent us this summary of his new book, published by Harper Collins in February. Watch our next issue for a review by Yves Talbot

Canadians are still proud of medicare but every day brings shocks to our confidence. Stories about waiting lists and doctor shortages compete with those about adverse drug reactions. Was medicare a mistake? In fact, Medicare was the right road to take and Canadians are renewing medicare with innovation.

Until the late 1950s, Canadians and Americans had similar systems and similar health. Now the US spends over 14 per cent of their economy on health while we spend less than 10 per cent. Half of this difference is due to higher overhead in the US private system. Canadians get fewer MRI scans and heart operations but we get more bone marrow transplants, doctors' visits, and prescription drugs as well as more care in hospitals and nursing homes. Canadian life expectancy is now 2 1/2 years longer and our infant mortality rate is 30 per cent lower. Finally, medicare gives our manufacturers a \$6 per hour per employee advantage over their American competitors.

Medicare is sound but we need to change the way we deliver health services

Canadians first started to debate medicare a hundred years ago, when our main health problems were acute illnesses like diphtheria and tuberculosis. But as we implemented medicare, starting in Saskatchewan in 1947, Canada changed from a young country with mainly acute illness to an aging country where the main health problems are chronic illnesses like diabetes and mental illness.

Unfortunately, our health system was built to provide care for acute illness. Canada provides world-class care for heart attacks and car accidents but too many chronic illnesses fester without proper follow up. Former Saskatchewan premier and father of medicare Tommy Douglas, always claimed that implementing public insurance would be relatively easy

compared with the more difficult problem of reorganizing the health delivery system. In a speech in Montreal in 1982, he bemoaned, "We have a health delivery system that is lamentably out of date."

Most health care stories seem to concern money.

Sometimes it is stated simultaneously that "health costs are spiralling out of control" and that "our health care system is dangerously under-funded." In fact, costs are not excessive but neither is the system drastically underfunded. The main issues concern management rather than money. Costs have increased in the last five years, but this followed five years of restraint. Canada actually spends slightly less of its GDP on health care now than it did in 1992.

On the other hand if we need more money for public coverage of drugs or to catalyze reform, the federal government is flush. The federal government is running a surplus of \$8 billion even though the Liberals have cut the federal government contribution by one-third since 1993. All told, the federal and provincial governments have cut taxes collectively to the tune of \$50 billion per year, enough to pay for universal home care, long-term care, pharmacare, and double the budget for the military.

A main theme for Prescription for Excellence is that we don't need to spend a lot more on health care to give Canadians a much more effective system. But it is patently false to claim that governments are broke and that Canadians must wait indefinitely for the fulfillment of the promises the Liberals made in the last three election campaigns.

Canadians can't get their concerns about medicare on the public agenda

Despite the media's voracious appetite for health care stories, too many

PRESCRIPTION FOR EXCELLENCE (continued)

are spun by politics. Between the high-powered misinformation generated by Canadian free-marketers and the media-savvy pressure tactics from health care's powerful interest groups there's very little room for good news stories about medicare's modernization. In fact, there are inexpensive solutions to medicare's problems. Shift. They have been developed somewhere across this great country by the Hundreds of thousands of Canadians who work in health care have developed.

We can fix medicare's problems — with innovation

We have a health system, which is poorly designed to manage chronic illness and frailty. As a result, too many hospital patients should actually get care elsewhere, too many chronic disease patients develop preventable complications, and too many people develop illnesses, which are totally preventable. At the beginning of medicare, patients with complicated problems were admitted to hospital for tests and consultations. Now, these patients often face an endless series of waits and delays to get the care they need. Finally, double-digit inflation threatens public and private drug plans.

Across the country, approximately 10 per cent of hospital patients are waiting for a bed in a long-term care institution and another 10-20 per cent could leave hospital if there were appropriate home care services for them. Calgary's comprehensive palliative care services enable people to die in comfort, out of hospital. Fewer than 40 per cent of cancer patients die in hospital compared with 70 per cent in the rest of Canada. Victoria pioneered the 'Quick Response Team' or QRT program in the late 1980s ensures that ER patients get the care they need to safely go home. In Saskatoon, better home care means that less than one percent of hospital beds have nursing home patients. As we have become more successful in treating acute manifestations of heart disease like heart attacks, the number of patients with end stage disease or

congestive heart failure (CHF) has soared. Because it is tricky to manage, approximately 20-25 per cent of patients with CHF are re-admitted to hospital within a month of discharge. In Sault Ste. Marie, the Group Health Centre ensures that a home care nurse sees every CHF patient and reduced readmissions by 60 per cent.

The Northwest Territories developed a diabetic program where public health nurses ensure comprehensive follow up. As a result, no diabetic has ever lost his or her kidneys due to complications of his/her disease.

Most diseases are preventable. With what we know now, we could prevent over 80 per cent of the cases of heart disease, diabetes, lung cancer, and chronic lung disease freeing up more than 6000 hospital beds. As in other aboriginal communities, diabetes rates have soared in the Kahnawake reserve south of Montreal. However, the community's school diabetes prevention project may have stabilized the disease in that community. Vancouver has stabilized the epidemic of HIV in intravenous drug users in the troubled downtown eastside neighbourhood.

Many Canadians lack family doctors and many have to wait months to get tests or see specialists. However, Canada actually has more physicians than ever. Better teamwork is the key to access. In southwestern Saskatchewan, one physician working in a team with 3 nurse practitioners looks after 3200 patients, over twice the Canadian average. In Hamilton, teams of mental health counsellors, family doctors, and psychiatrists have increased the numbers of patients treated for mental health problems by 900 per cent while decreasing referrals to the regional psychiatry clinic by 70 per cent. In Sault Ste Marie, a taskforce reduced the time from mammogram to breast cancer diagnosis from 107 to 18 days.

Canada's bill for prescription drugs continues to escalate at more than 10 per cent per year. But, far too many patients take drugs they shouldn't and others take

expensive new drugs when older, cheaper ones would work as well, or better. A number of non-drug therapies show great potential to reduce our reliance on pharmaceuticals. Cognitive behavioural therapy (a brief 'talking therapy') effectively treats pain, anxiety, and mild to moderate depression. Acupuncture provides excellent pain control and improves cardiorespiratory fitness.

Better teamwork between doctors and pharmacists can greatly improve the quality of prescribing. In North Vancouver, a program where a pharmacist provides education to doctors in their offices saves two dollars for each dollar it costs. British Columbia's reference drug program substitutes cheaper but as effective older drugs for new drugs and is estimated to save nearly \$50 million per year.

We can implement all of these innovations without private finance or for-profit delivery. In fact, private sector solutions tend to increase costs while decreasing quality.

Conclusion

Medicare is at a crossroads. The right shrieks privatization while the left pleads for a lot more money. Most Canadians oppose market solutions, but we understandably balk at continuing to pump public dollars into what sometimes seems a bottomless pit. Prescription for Excellence demonstrates that we can solve medicare's apparently intractable problems with innovation.

Let's speed up medicare's renewal by spreading the best practices as quickly as possible. As our problems wane, so will the demand that we change the basic values upon which medicare was founded. It's not too late to save medicare. It's not too early to pitch in to help. Let's take our final direction again from Tommy Douglas — "Courage my friends. 'Tis not too late to make a better world."

WORTH REPEATING: INDUSTRY AND HEALTH A DEADLY MIX

On February 10th, 2004, the Toronto Star published on its Editorial Page this excerpt of an open letter to the Prime Minister, signed by 800 Canadians and experts from 30 countries.

We are writing you to express our deep concern with your government's proposal to replace Canada's Food and Drugs Act with a new health protection legislative regime.

We have noted a series of changes announced by your new government that reflect the commitment to building a "21st-century economy." A key element appears to be the redesign of the federal approach to health and safety regulation in order to create an "advantage" for industry by means of weaker safety standards.

Of particular concern are Health Canada's proposals to:

- ◆ Abandon the precautionary principle to a narrow risk-benefit regime.
- ◆ Shift the burden of proof from industry to the public - products are presumed safe unless harm is proven.
- ◆ Speed up drug approvals.

- ◆ Allow direct-to-consumer advertising of prescription drugs.

If the government abdicates its health protection duty of care, Canada's health-care system will not be able to cope with the negative health outcomes. The negative effects of these proposed regulatory changes would also be felt throughout the international community. Societies need both commercial and guardian functions. But these two types of work are contradictory and are prone to corruption if they stray across either their moral or functional barriers. When the governments in Canada mix trade and industry objectives - like deregulation, self-regulation and privatization - into health protection functions, people are killed.

These are the painful lessons from the tainted blood disaster, drinking water contamination, adverse drug reactions, and deadly pathogens in food.

Canada has not learned from the mad cow crisis in Britain. Food safety and food promotion functions must not be housed within the same government agency. The federal regulator may have helped the Canadian beef industry economically in the short term by not adopting precautionary measures to stem the spread of mad cow disease. However, in the longer run, this lack of attention to safety will cost the industry much more.

The purpose of health protection legislation is to safeguard health and safety, not trade and investment.

Government can't regulate to protect health and the environment if it is in bed with the industries it regulates. What kind of society builds a "21st-century economy" by exposing those least able to defend themselves - children - to uncontrollable hazards and unknown risk?

CHC URGENT ACTION ALERT

The Medical Reform Group signed on to the following call in March 2004. We also reproduce following a fact sheet summarizing the issues of federal bill C-56 [revised in November 2003 at bill C-9] published January 14, 2004 by Doctors Without Borders

Affordable Medicines for Developing Countries: Tell the Federal Government to Fix Bill C-9

First introduced in November 2003 (as Bill C-56) and reinstated in February 2004, Bill C-9 has the potential to alleviate great suffering and save many lives by allowing Canadian generic pharmaceutical companies to make lower-cost medicines and export them to developing countries that cannot make their own.

Yet this objective will be undermined by Big Pharma unless flaws currently found in the bill are fixed.

The time to act is now! In the next few weeks, Canadians need to tell their Members of Parliament and the Prime Minister that Bill C-9 must be fixed before it is passed.

Unless amended, Bill C-9 will not lead to cheaper medicines for people most in need.

E-mail a letter directly to Prime Minister Martin from this website, by visiting:

http://www.aidslaw.ca/Maincontent/issues/cts/patent-amend/letter_Martin.htm

Richard Elliott, Director, Legal Research & Policy / Directeur, politiques et recherche juridique, Canadian HIV/AIDS Legal Network / Réseau juridique canadien VIH/sida, 890 Yonge Street, Suite 700, Toronto, Canada M4W 3P4

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E-mail: relliott@aidslaw.ca Web: www.aidslaw.ca

The Canadian HIV/AIDS Legal Network is a partner organisation of the AIDS Law Project of South Africa, and a non-governmental organization in Special Consultative Status with the Economic and Social Council of the United Nations.



***Fix Bill C-56: Ensure Access to Medicines in the Developing World
“If Canada is serious about increasing access to medicines in the
developing world it must fix the flaws in Bill C-56 now.”***

-Dr. Leslie Shanks, President Médecins Sans Frontières (MSF) Canada

On November 6, 2003, Bill C-56 was introduced in the House of Commons. The Bill proposes to amend the Canadian Patent Act and the Food and Drugs Act to allow the export of generic medicines to developing countries. This step was taken to implement the terms of the unanimous August 30, 2003 WTO agreement. This agreement allows countries with little or no manufacturing capacity to import affordable generic versions of medicines from countries where there is manufacturing capacity but where those medicines are patented.

Bill C-56 had two parliamentary readings in November 2003 and it will be subject to parliamentary committee hearings before it has its final reading in early 2004. MSF believes public debate on the bill will provide a crucial opportunity to insist that the Canadian government amend the bill so that it can achieve its objective: to increase access to medicines for poor peoples in the developing world.

MSF commends the Canadian government for being the world's first government to seek to implement the August 30, 2003 WTO agreement. However, MSF strongly urges Canada to neither bow to pressure from the patent protected pharmaceutical industry, nor veer from its endorsement of both the letter and spirit of the August 30, 2003 WTO agreement. This is a matter of life or death for millions of people. MSF calls on the Government of Canada to make Bill C-56 a fully effective tool to increase access to medicines for peoples in the developing world.

At the November 2001 Ministerial Conference of the WTO in Doha, Qatar, Canada endorsed the Doha “Declaration on the TRIPS Agreement and Public Health,” which recognized that patents can impede access to affordable medicines. The Doha Declaration stated that TRIPS “can and should be interpreted and implemented in a manner supportive of WTO Members’ right to protect public

health and, in particular, to promote access to medicines for all.”

Much of the language in Bill C-56 reflects the historic Doha Declaration that prioritizes patients over patents. But MSF has identified four issues that if unaddressed, will make Bill C-56 all but irrelevant to people needing medicines in the developing world. Bill C-56 must not be a step backwards from Canada’s international commitments. If Canada is to avoid setting a bad international precedent, the four proposed changes to the issues outlined below are imperative.

Issue 1: Patent Holder’s “Right of First Refusal” - Sections 21 04 (6)(a) & (7)(a)

When a developing world government determines that health needs demand lower prices for drugs protected by patent, it can ask the patent holder to voluntarily lower its price to make the drug affordable or it can use flexibilities in the TRIPS Agreement to lower drug prices. Under the terms of the TRIPS Agreement, the patent holder can — within a reasonable period of time and on “reasonable commercial terms” — voluntarily grant a license to a third party, such as a producer of generic drugs, in exchange for a royalty payment. (a “voluntary license” agreement.)

If no such agreement can be reached, the generic producer can seek a “compulsory license” from the appropriate authority under that country’s laws. The compulsory licenses authorize the generic production of a medicine and set the royalty that must be paid to the patent holder. TRIPS requires that there be “adequate remuneration” for the patent holder.

However, in countries with little or no generics manufacturing capacity, there is no potential or actual domestic competitor to the patent holder to obtain a voluntary license nor any manufacturing capacity to meet an un-addressed need through compulsory licenses. The August 30, 2003 WTO agreement seeks to redress the lack of control, which countries with

little or no manufacturing capacity have, by allowing generic versions of patented pharmaceutical products to be exported from countries where generics manufacturing capacity does exist.

Bill C-56 seeks to implement this August 30, 2003 WTO agreement. However, by including the “right of first refusal” to Canadian patent holders in sections 21 04 (6)(a) & (7)(a), the Bill effectively undermines the intent of the WTO agreement. The provision grants the Canadian patent holder 30 days to meet the terms of an agreement that a Canadian generic company has negotiated with a developing nation¹.

Only if the Canadian patent holder ‘refuses’ to take up the terms of the negotiated agreement, can the Commissioner of Patents then set a reasonable royalty payable to the patent holder, and issue a compulsory license for export. The company that holds patent rights for a particular drug in Canada may also hold patent rights for the same drug in a developing nation.

By granting this “right of first refusal” to the Canadian patent holder, Bill C-56 gives the patent holder an incentive not to participate in TRIPS voluntary licensing agreements for the developing world so undermining the flexibilities that exist in the TRIPS agreement. Using this provision, the patent holder can effectively control or take over any counter-measure pursued by the developing world government that seeks to use out-of-country generic manufacturing capacity to meet an un-addressed health need.

The “right of first refusal” provision of Bill C-56 also undermines the intent of the August 30, 2003 agreement by creating a disincentive for Canadian generics companies to negotiate with developing world governments, because the deal may be taken over by the Canadian patent holder.² In MSF’s HIV/AIDS treatment and care experience, it has been generic competition and their cheaper medicines which have enabled us

CHC URGENT ACTION ALERT (continued)

to treat thousands of patients. If a Canadian patent holder is given the right of first refusal over a negotiated contract, why would any generics company engage in the transaction costs of negotiating a deal? The net effect may well be a further stifling of the market competition that would drive pharmaceutical prices down. This will continue to keep essential medicines out of the reach of people or nations with little or no purchasing power.

In terms of incentives that strengthen the rights of patent holders, the “right of first refusal” provision of Bill C-56 is actually “TRIPS plus”, meaning that it creates extra private rights for patent-holding pharmaceutical companies that are not required by the WTO TRIPS Agreement. This provision will not result in price reductions, but it will render the bill ineffective from outset.

Recommendation: Drop ‘the right of first refusal’ from the Bill. Delete sections 21.04(6)(a) and 7(a), and remove the corresponding references to these in section 21.05(5).

Issue 2: Limiting patented pharmaceutical products covered - Schedule 1

Bill C-56 creates a limited list of scheduled pharmaceutical products that are patented in Canada and covered by the provisions of the Bill. Many medicines patented in Canada and used in the developing world do not appear on the list.

MSF recommends that there be no Schedule 1. The November 2001 Doha Declaration recognizes the responsibility and sovereignty of countries to determine their own health needs. If Bill C-56 aims to help poor countries to get access to the pharmaceutical products they need, then this Schedule and its updating mechanism is unnecessary and onerous. While the Schedule is intended to give clarity about which medicines are covered by Bill C-56, it is clearly inappropriate for Cabinet to decide what pharmaceutical products from Canada are to be allowed to meet requirements determined by another sovereign nation.

The current bill includes a very limited schedule of less than 50 drugs patented in Canada. Some important

drugs do not appear in Schedule 1. For example, Nevirapine, which is widely recommended as an option to prevent transmission of HIV from mother to child in a single dose regime which is safe and effective, as well as simple to use and low cost. It is patented for use in Canada, but it is not on the Schedule 1 list. An alternate drug – AZT — is included in the list for export. The key point is that developing countries must be allowed to decide for themselves what products are needed within their own health care system. All countries at the WTO, including Canada, agreed to this right at the historic meeting of the WTO in Doha, Qatar in November 2001. There should be no back-tracking on this, and thus no list in Bill C-56. - Dr. Leslie Shanks, President, Médecins Sans Frontières Canada

Recommendation: Drop Schedule 1 from the Bill

Issue 3: Limiting the developing countries eligible under the Bill - Schedules 2, 3, and 4

The August 30, 2003 WTO agreement does not impose limits on which countries can benefit from flexibilities in TRIPS. In the Bill, the scheduled countries are those recognized by the UN as “least-developed”, both non-WTO members and WTO members. But other “developing countries” are only included if they belong to the WTO; in other words, non-WTO countries are excluded. This means countries such as East Timor, Turkmenistan and Vietnam could not benefit from importing more affordable medicines from Canadian generic producers. MSF recommends that there are no country restrictions. The Patent Act Amendment should fully reflect the letter and spirit of the Doha Declaration, which refers to “access to medicines for all.”

Recommendation: Drop the lists or include all developing countries that are not members of the World Trade Organization

Issue 4: Limited who can procure pharmaceutical products – Section 21.08 (2)(f)

The Bill limits procurement of medicines to “government and agents of government”. NGOS and private sector entities are not “agents” of government

and thus might not be able to enter a contract with a Canadian generic manufacturer that would seek a license to export pharmaceutical products. Nothing in the WTO August 30 agreement allowing for export of generic pharmaceuticals limits the procurement of pharmaceutical products to governments and agents of governments.

Recommendation: Change the bill to allow for non-governmental organizations and others to procure medicines from Canadian generic manufacturers

Conclusion

MSF encourages the Canadian government to continue to move quickly to pass Bill C-56 with the recommended changes outlined above. We urge ministers, Members of Parliament, government officials, health professionals, citizens and organizations concerned about global health and access to medicines to make the changes or encourage the Canadian government to make the necessary changes to the bill before passing it, in the interest of “access to medicines for all.”

For Canada’s Bill C-56, the question remains: “Will Canada lead or will it flounder?”. For better or for worse, Canada’s approach will set a precedent for other nations that have a strong capacity to manufacture generic drugs. If Canada fails to make the necessary amendments to Bill C-56, it will flounder. This would be a lost opportunity and may set a disastrous international precedent that would take years to overcome. In the interim, millions of people with treatable diseases would lose their lives because of lack of access to medicines. If Canada leads, by ensuring that its legislative changes meet both the letter and the intent of the 2001 and 2003 WTO agreements, it will demonstrate a visionary approach to global health for the 21st century. — Dr. James Orbinski, Former International President, Médecins Sans Frontières, Research Scientist & Associate Professor, St. Michael’s Hospital, University of Toronto

TWO-TIER MEDICINE THREATENS EQUITABLE HEALTH CARE DELIVERY

Periodically, the guerilla-warfare style battle over Canadian one-tier health care breaks out into the open. Then, it returns to the shadowy world of back-room negotiations between federal and provincial governments.

Early in December, British Columbia's provincial government passed legislation mandating penalties of up to \$20,000 against doctors who accept payments for medically insured services. Within two weeks, the government changed direction, refusing to proclaim the bill, and sending it back to the drawing board – or to oblivion.

Understanding this bizarre drama requires some background. For a host of medical services, Canada has two-tier health care. Patients can pay for getting quicker and better services, and those who cannot pay may not get the service at all. Such services include drugs, home care, and eye care.

For physician and hospital services, however, things are different. In 1984, the Canada Health Act reinforced the principle that Canadians should have access to medically necessary physician and hospital services according to need, rather than ability to pay. The act allows the federal government to penalize provinces that allow user charges for

physician and hospital services. For each dollar charged to the patient, the federal government can withhold a dollar of transfer payments to the offending province.

The act stopped user charges cold, and established Canada as the world's leader in equitable access to physician and hospital services. But in the years since the federal government passed the act, user fees, and the two-tier care that goes with them, has crept back. Canada Health Act violations happen for a number of reasons.

First, Canada has serious problems with waiting lists for services such as elective orthopedic surgery, and sophisticated diagnostic tests such as magnetic resonance imaging (MRI). Those waiting lists create an appetite for queue-jumping among those who can pay.

Second, it's not simple to catch the cheaters. Patients who pay to get the benefit of quicker service are unlikely to complain. Queue-jumping happens in for-profit surgical and radiology facilities as a quiet understanding between doctor and patient.

Third, there are two areas in which it is legal for money to catapult patients to the front of the line. The Boards in charge of injured workers pay larger amounts for diagnostic and therapeutic services than provincial health plans, and injured workers get quicker service. The same is true for insurance companies seeking assessments for patients who have suffered from automobile accidents.

Fourth, the federal government has been lax in enforcing the act. In October 2002, Auditor-General Sheila Fraser reported that the Health Department is sitting on at least 21 outstanding complaints about provincial violations of the act, 11 of which had been unresolved for five years or more.

The picture has changed little since that time. So little, in fact, that a coalition of groups concerned about equal health care access, including the Canadian Health Coalition and the Council of Canadians, has taken the Health Minister to court for failing to enforce the act.

This doesn't mean that paying to jump the queue is epidemic. Over-

whelmingly, provinces and doctors play by the rules. Major Canada health act violations are largely restricted to two provinces, Alberta and British Columbia, whose governments sympathize with private pay and with investor-owned for-profit health care delivery. Violations are also restricted not only geographically, but also to elective surgery – particularly orthopaedic procedures such as joint replacements, and cataract surgery – and expensive diagnostic tests such as MRI.

So, what happened in British Columbia? The federal government prefers to negotiate with the provinces behind the scenes rather than penalizing them openly for Canada Health Act violation. BC health minister Colin Hansen described his legislation as a response to increasing pressure from the feds in these negotiations. Naturally, the legislation upset for-profit facilities that were charging patients. They threatened closing down, and therefore increasing waiting lists.

Their reaction, of course, confirms how important the extra charges are to the facilities. As Hansen himself said at the time the government passed the legislation, "if these clinics have been operating lawfully up until now, there's no reason why this is going to affect them at all." Their reaction tells us that they had not been operating lawfully.

Nevertheless, apparently in response to pressure from the for-profit providers, the government backed off. Or was it that the federal government turned down the heat? With a new prime minister at the helm, BC Premier Gordon Campbell suggested, "I think it may well turn out that we don't need (the legislation) at all."

Overwhelmingly, Canadians want equitable access to high quality health care. The best solution to Canada Health Act violations is reduction in waiting lists to acceptable levels. Federal action to ensure provinces do not allow paying to jump the queue will hasten the day when no Canadian will face intolerable waits for diagnosis or treatment.

First published January 6, 2004 as one of Dr. Gordon Guyatt's biweekly columns in the Winnipeg Free Press.

CHC URGENT ACTION ALERT (continued)

(Endnotes)

¹ See Section 21 04 (6)(7) of Bill C-56: An Act to amend the Patent Act and the Food and Drugs Act. 2nd Session, 37th Parliament, 51-52 Elizabeth II, 2002-2003. House of Commons, Canada. Tabled November 6, 2003. Available at: http://www.parl.gc.ca/37/2/parlbus/chambus/house/bills/government/C-56/C-56_1/C-56_cover-E.html

(Accessed November 8, 2003).

² Canada Press. PM proposes law to allow drugs for poor nations. CTV.Ca Website. November 6, 2003. Accessed November 7, 2003. Available at http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/1068147930736_63557130///?hub=Canada

CANADIAN HEALTH COALITION CALLS FOR FEDERAL MORATORIUM ON PUBLIC-PRIVATE PARTNERSHIPS

CHC Chair Kathleen Connors sent the following letter to Federal Health Minister on February 24, 2004.

I am writing you on behalf of the Canadian Health Coalition on the issue of public-private partnerships (P3s) in health care. Today, across the country, concerned citizens are organizing local media conferences to alert the public to current provincial government plans to privatize hospitals – a core component of our national health care system.

As Canada's federal Health Minister you must not stand idly by as provincial governments threaten the integrity of Medicare by signing contracts with private for-profit hospital consortiums. In light of the gravity of the situation we are requesting that you use the authority of your office to: 1) call for an immediate moratorium on any initiatives to privatize the delivery of health care services including public-private partnerships; and 2) refer the matter to the Health Council of Canada for an evidence-based and transparent examination.

It is no longer plausible for the federal Minister of Health to claim that ownership of health care delivery does not matter, or that medicare is fully protected from international trade agreements. This denial is no longer plausible in light of the evidence.

The Health Council of Canada should examine all the evidence pertaining to the cost, safety, impact on international trade agreements, and benefits. In particular all proposed contracts should be examined in an open and transparent way, including those with Healthcare Infrastructure Company of Canada, a corporate consortium, which is bidding on contracts to build and own for-profit hospitals in Ontario, British Columbia, Alberta and Québec.

The same private corporations are bidding on contracts across the country. They see the public health system as a potential place to make profits. The group of companies that has won the contracts to build the first two P3s in Ontario – a consortium of companies is also bidding on the B.C. projects. These corporations vying to take over our hospitals have controversial records in Britain where the most extensive experiment with P3s in the world has been a disaster.

P3s threaten the future of Medicare. They cost much more than public non-profit hospitals. Because the buildings and profit-taking suck up so much money, the clinical side of the hospitals gets cut. In Britain, an average of 30 per cent of staff and 26 per cent of hospital beds have been cut according to the prestigious British Medical Journal.

These hospitals are not accountable – they answer to shareholders who are looking for profits - not to the public like non-profit hospitals. They suck up so much money that they reduce the scope of services offered under the public health system. They provide both the incentive and the opportunity for for-profit corporations to push service charges, user fees and two tier health care in their endless search for more profits. In other words, the public pays and the private profits. That is not a partnership.

There is no evidence that the people running for-profit hospitals or clinics know anything more about running these facilities better than the people who administer them on a not-for-profit basis.

The for-profit consortiums recruit the same managers and administrators. The big difference is that for-profit ownership does not have the same

obligations. Their job is to serve the investors in the consortium, not the community.

It is not in the public interest to transform public, not-for-profit, transparent, and accountable health care contracts into private, for-profit, and secret opportunities for corruption and fraud.

In the words of the Romanow Commission's Final report: "Rather than subsidize private facilities with public dollars, governments should choose to ensure that the public system has sufficient capacity and is universally accessible. In addition, as discussed in Chapter 11 ('Health Care and Globalization'), any decisions about expanding private for-profit delivery could have implications under international trade agreements that need to be considered in advance."

In addition, opening up the not-for-profit health care delivery system to private for-profit delivery, including foreign investment, threatens the current protection for Canada's Medicare system in the NAFTA and the GATS. This threat has been documented by the Romanow Commission in its research and final report.

For example, GATS Article 1:3(c) exempts any "service which is supplied neither on a commercial basis nor in competition with one or more service suppliers". How could this provision be applied to situations involving a mix of governmental, private for-profit and private not-for-profit delivery? [Jon R. Johnson, *How Will International Trade Agreements Affect Canadian Health Care?*, Romanow Commission Discussion Paper No. 22, September 2002, p.18].

CHC CALLS FOR FEDERAL MORATORIUM ON PUBLIC-PRIVATE PARTNERSHIPS (continued)

The Romanow Commission on the Future of Health Care in Canada found no evidence that a greater role for private for-profit health care delivery will deliver better or cheaper, or improved access. Indeed the expansion of for-

profit delivery into Canada's Medicare system has been described as "a perversion of Canadian values". This is because "Canadians view medicare as a moral enterprise, not a business venture". (Romanow Commission, Building on Values, p. xx).

We expect a response from you on this urgent matter at your earliest opportunity.

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HEALTH MINISTRY SIT-IN FIRST STEP IN ESCALATING CAMPAIGN TO STOP THE PRIVATE HOSPITALS

On Thursday, March 4th, the Ontario Health Coalition staged a sit-in at the Ministry of Health offices in Toronto to send a message to stop the first two private hospitals since the inception of Medicare. The Health Minister's office agreed to more disclosure of documents pertaining to the deals, however did not agree to cancel the deals yet.

With 120 supporters demonstrating outside the building, nine Coalition members entered the Hepburn block with chairs and tents. After an hour and a half, access to the building was cut off, locking doctors, nurses, healthcare workers and patients and a few members of the press inside.

Charles Beer, Special Advisor in Minister Smitherman's office, agreed to meet with two representatives. Natalie Mehra and Cathy Pounder brought the OHC's message to the Minister's office; they reported their outrage at the secrecy

of the ongoing P3 negotiations and demanded an end to the Brampton and Ottawa private hospital deals. Beer told Mehra and Pounder:

1. The government would disclose its information on the deals today, and the hospitals would disclose their information next week. (He did not commit to disclosing all information; we will review what is disclosed and see what is missing at that time.)
2. He also committed to "broad public consultations" on the government's policy direction regarding private hospitals.
3. He did not agree to halt or end the negotiations of private hospitals, nor did he offer any justification for their continuation.

The public pressure is having some effect. It is forcing some disclosure and will force more; it is forcing a review of the policy, and making the government

look more closely at what is becoming a major public debate. We believe that public pressure is necessary to stop the first two private hospitals since the inception of Medicare. It can be done.

The Coalition has called a mass public rally and march-the biggest demonstration against the Liberals since this government was elected-***on April 3rd starting at Nathan Phillips Square at noon***

For more information, contact Natalie Mehra at the Ontario Health Coalition
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