

MEDICAL REFORM

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YOUR MONEY AND YOUR LIFE: THE CONSEQUENCES OF INVESTOR OWNED PRIVATE FOR-PROFIT HEALTH CARE DELIVERY

P.J. Devereaux

When discussing our health care system it is important to distinguish between funding (who pays for our health care) and delivery (who owns and runs our health care facilities). Currently, hospital services in Canada are publicly funded—we pay through our taxes. In terms of delivery, although commonly referred to as public institutions, Canadian hospitals are almost all private not-for-profit institutions owned and operated by communities, religious organizations, and regional health authorities.

The debate concerning for-profit versus not-for-profit provision centers on delivery: whether we should introduce investor-owned private for-profit health care facilities into our dominantly private not-for-profit health care delivery system. Advocates of investor-owned private for-profit health care delivery argue that the profit motive optimizes care and minimizes costs. However, some fear for-profit facilities are more likely to respond to financial pressures by cutting the quality of care and charging more to maintain shareholder returns. These viewpoints have resulted in a heated debate.

A group of researchers, of which I am one, at McMaster University, the University of Toronto, the University of Western Ontario, the University of Ottawa, the University of British

Colombia, and the University at Buffalo have come together to undertake research to directly inform this debate. Our goal is to move the debate away from ideology and make it evidence-based. In a previous edition of the Newsletter of the Medical Reform Group (Issue 124, volume 22, Number 3, Winter, 2003) I reported the results of our first two studies that were published in the Canadian Medical Association Journal (CMAJ) and the Journal of the American Medical Association (JAMA).

Our first study included data on more than 38 million patients and demonstrated higher risk adjusted death rates among patients receiving care at investor-owned private for-profit hospitals compared to patients receiving

care at private not-for-profit hospitals.¹ Our findings suggested if we were to convert our Canadian hospitals to investor-owned private for-profit institutions, we would incur more than 2100 additional deaths a year in Canada. This number of deaths is in the range of how many Canadians die each year from colorectal cancer, motor vehicle accidents, or suicide.

Our second study included data on more than 500,000 patients followed for a year and demonstrated once again higher risk adjusted death rates among patients receiving care at investor-owned private for-profit dialysis facilities compared to patients receiving care at private not-for-profit dialysis facilities.² Our study showed that if American patients received care in private not-for-profit dialysis facilities instead of for-profit facilities, approximately 2,500 fewer patients would die each year. Further if we were to convert our Canadian private not-for-profit dialysis centres to investor-owned private for-profit centers, we could expect approximately 150 additional deaths each year among Canadian patients receiving dialysis.

Our first two studies clearly documented the negative health consequences (i.e., increased death rates)

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MedicalReform

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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.

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at investor-owned private for-profit compared to private not-for-profit inpatient and outpatient health care facilities. Uncertainty, however, remains about the economic implications of these forms of health care delivery. Studies evaluating the economics of health care delivery usually evaluate costs, charges, or payments for care.

From the perspective of a service provider, costs represent how much the provider paid to provide care, charges represent how much the provider billed the payer, and payments represent how much the provider received for the care. In the context of publicly funded health care, the central policy question is how much government will pay for care delivered by investor-owned private for-profit versus private not-for-profit providers. We therefore undertook a study to inform this issue and we have recently published this study in the CMAJ.³

We used a study methodology called systematic review and meta-analysis which synthesizes the results of existing high quality studies that all address a single question, in this case: "is there a difference in payments for patient care received at private for-profit compared to private not-for-profit hospitals?" Using this study methodology we developed explicit criteria for deciding whether a study was eligible; conducted a comprehensive search to identify all relevant studies; applied eligibility criteria to potentially eligible studies in an unbiased manner; examined the quality of the eligible studies; and conducted a rigorous statistical analysis of the data from the studies that ultimately prove eligible and of adequate quality.

Our extensive search identified 7,500 medical articles. Over seven hundred of these passed an initial eligibility screen. We then undertook an extremely important measure to eliminate

bias in selecting which studies to include in our systematic review. We trained research staff to read through all the articles and use a black marker to obscure the results of the studies. Two reviewers then independently examined these articles with the results blacked out and determined study eligibility. As a result of this process we could not select studies to reach a specific conclusion.

Ultimately eight studies including data on over 350,000 patients met eligibility and quality criteria for our systematic review. Our results demonstrated that payment for care was 19 per cent higher at the investor-owned for-profit hospitals compared to the private not-for-profit hospitals. Canada currently spends \$120 billion annually on health care, and hospital care accounts for 32 per cent of overall expenditures. Therefore, if Canada switched to investor-owned private for-profit hospitals the Canadian governments would pay an extra \$7.2 billion in annual health care costs.

Given our findings of higher payment for care at investor-owned private for-profit hospitals some may ask why this occurs. Private for-profit facilities have to generate profits to satisfy shareholders, pay high executive bonuses, and have high administrative costs. Not-for-profit providers do not have investors and have lower executive bonuses (typically 20 per cent lower), and administrative costs (typically 6 per cent lower). In an editorial that accompanied our publication, Harvard researchers Woolhandler and Himmelstein provided an additional explanation: greed.

Another question that some may ask is whether the U.S. data from

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our systematic review is relevant to Canada. There are three reasons why our results are directly relevant to Canada. First, the statistically significant higher payments for care at a wide range of investor-owned hospitals spanned a 12 year period, despite important changes to the American health care system during this time (for example, the introduction of managed care, HMOs, prospective payment systems). This suggests that no matter what the context the investor-owned hospitals result in higher payments for care. Second, payments proved greater in for-profit facilities among both publicly funded patients and among privately funded patients.

Third, if Canada moves to for-profit hospitals, the same large American hospital chains included in the review would be purchasing Canadian hospitals. There is no reason to think they will not bring their same management style with them across the border.

Our systematic review shows substantially higher payments for patient care at investor-owned private for-profit hospitals. Combined with our previous two studies that showed higher death rates in investor-owned private for-profit hospitals and dialysis centres, this research raises serious concerns about moves to private for-profit care. Evidence strongly supports a policy of not-for-profit health care delivery. ♦

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2. Devereaux PJ, Schunemann HJ, Ravindran N, Bhandari M, Garg AX, Choi PT, et al. Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: a systematic review and meta-analysis. *JAMA* 2002;288(19):2449-57.
3. Devereaux PJ, Heels-Ansdell D, Lacchetti C, Haines T, Burns KE, Cook DJ, et al. Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis. *CMAJ* 2004;170(12):1817-24.

MRG TO PREMIERS: ABANDON THE FIREWALL

The Medical Reform Group today called on the Premiers, meeting to prepare their strategy for negotiations with Paul Martin, to accept the need for national health care programs.

"The narrow-minded selfishness of some Premiers could destroy our national, public health care system," said MRG spokesperson Dr. Gordon Guyatt. "The Premiers must accept the federal government's responsibility to ensure national standards, and accountability for the money it provides to the provinces."

A group of prominent Albertans, including opposition leader Stephen Harper, called in early 2001 for a firewall that would allow Alberta to violate national policies, including the Canada Health Act. This firewall mentality continues to reflect the attitudes of some Premiers, including Ralph Klein and Gordon Campbell, as they call for federal money with no strings attached.

The firewall mentality both violates the will of the electorate in the last federal election, and the best interests of Canadians. All major parties in the election professed commitment to universal, high quality, publicly funded health care. Canadians voted overwhelmingly for parties most strongly committed to these principles. Polls show that even in Alberta, where Conservatives dominate both federally and provincially, the electorate is split between federalist and isolationist approaches to health care funding and delivery.

Publicly funded health care delivered by not-for-profit providers is both more equitable and more efficient than the two-tier, American-style approaches to funding and delivery that Ralph Klein advocates. The Romanow report recognized our need for national standards of care, national targets of health care delivery goals, a national home care program, and a national pharmacare program.

"It's up to the federal government to ensure that federal health care money is properly spent," said another MRG spokesperson, Dr. Ahmed Bayoumi. "That means national standards, and national programs, including home care and pharmacare. It's up to the provinces to accept the need for strings-attached money that ensures they will behave responsibly in keeping with the national will."

"Canadians don't want universal health care in some province, two-tier medicine in others," Dr. Guyatt concluded. "They don't want accessible home care and adequate coverage for prescription drugs in some provinces and not others. Canadians want national public programs that make high quality accessible across the country. The Premiers should realize that, and get on board." ♦

Released July 30, 2004

PUBLIC FUNDING, NOT FOR-PROFIT DELIVERY: HELP FOR UJJAL DOSANJH

The Medical Reform Group, an organization of physicians devoted to maintaining a high quality publicly funded, universal health care system, pledged today to help federal Health Minister Ujjal Dosanjh deliver on his commitment to stop creeping privatization. The MRG's letter to Dosanjh applauds his goals, and encourages him not to back down in the face of provincial intransigence.

Minister Dosanjh has said he wants to "stem the tide of privatization and expand public delivery" of health services. The MRG supports these goals, and believes the group can help make them happen.

"MRG members have conducted the systematic literature reviews that have confirmed increased death rates and higher costs in investor-owned for-profit health facilities," said MRG spokesperson Dr. Irfan Dhalla. "The MRG can help the Minister by ensuring the public

understands the importance of this evidence."

"With Premiers like Klein, Campbell and Charest asking the federal government to butt out on issues like enforcement of the Canada Health Act and investor-owned for-profit delivery, Dosanjh needs all the help he can get," added another MRG spokesperson, Dr. Rosana Pellizari. "Our doctors' group has the credibility to let people know that Dosanjh is on the right track, and the Premiers are not."

Public funding of health care, as Canada now has for physician and hospital services, is both equitable and efficient. When the majority of funding is private, as it is for prescription drugs, inefficiencies abound and costs explode.

Studies published in the top medical journals show that outcomes are better and costs are lower when private non-profit organizations like Canadian hospitals provide health services. Death

rates are higher, and charges increase, when investor-owned private for-profit companies deliver care.

For-profit corporations make money by diverting resources away from patients and into the pockets of their shareholders. Non-profit clinics and hospitals are able to spend less money on marketing and administration, and therefore spend more money on patient care. Yet, right-wing Premiers, including Gordon Campbell and Ralph Klein, want to increase investor-owned delivery of care in hospitals, surgical clinics, diagnostic test facilities, and home care.

"Canadian health care is hanging in the balance," Dr. Dhalla concluded. "The MRG will help Dosanjh ensure the outcome is what Canadians want, and need. ♦

Released August 3, 2004

THE PREMIERS' ANNUAL THEATRICAL PERFORMANCE: CONSENSUS MASKS CONFUSION

Michael Rachlis

Last week, Ontario Premier Dalton McGuinty hosted his 12 provincial and territorial colleagues in historic Niagara-on-the-Lake, Ont.

On Oct. 13, 1813, British Maj.-Gen. Roger Sheaffe marched his troops from the town's garrison to reinforce Gen. Sir Isaac Brock's men who were losing ground against the invading Americans at nearby Queenston Heights. The British/Canadian forces won and as a result we have medicare and annual premiers' meetings.

Now Niagara-on-the-Lake is known more as the picture-postcard

home of the Shaw Festival. In keeping with the setting, the conference featured a plot twist, unlikely stars and a surprise ending. Perhaps fittingly, the premiers' theatrical performance may well trump any history that might have resulted from their discussions.

On Wednesday afternoon, the premiers arrived to the sound of thunder and loud protests against privatization. Despite McGuinty's attempts at pre-meeting interprovincial diplomacy, the premiers were still deadlocked on the big-ticket issues of for-profit care and accountability to the feds for new money. But by Friday afternoon, the clouds had

parted, the premiers were best friends and many of the advocacy groups had joined in the love-fest.

British Columbia Premier Gordon Campbell fired up the love train with the idea that the feds should take over the costs of provincial drug plans. When Campbell became premier, B.C. had the country's most generous drug plan. But three years of cutbacks have slashed coverage. No doubt he plans further cuts if he is re-elected next year. Why not just unload the political and economic costs onto Ottawa?

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THE PREMIERS' ANNUAL THEATRICAL PERFORMANCE: CONSENSUS MASKS CONFUSION (continued)

Coincidentally, the Ottawa-based Canadian Federation of Nursing Unions brought three recommendations to Niagara-on-the-Lake, and one of them was for a federal takeover of provincial drug programs. Toronto economist Dr. Armine Yalnizyan, who authored the CFNU report, sensibly noted that Ottawa already sets most of the rules for drug therapy in this country, including writing the rules for licensure and patent protection. Ottawa could buy the country's drugs in volume and lower prices through tough negotiations with the manufacturers. Australia, another parliamentary federation, bulk-buys its drugs and has the lowest drug costs of any wealthy country.

Dynamic CFNU president Linda Silas hails from New Brunswick and used her connections with Premier Bernard Lord and Newfoundland and Labrador Premier Danny Williams to lobby them. By Thursday afternoon, a national pharmacare plan was the talk of the town. Provincial delegates were visibly relieved as they worked through the night and early morning on the details of the final communiqué.

By Friday afternoon when the premiers met the media, the love-in was in full flight. McGuinty declared that the premiers had made history. Claiming to speak for baby boomers and Gen-Xers from coast to coast, he noted that, as his parents had given their children medicare, now he and his colleagues could pass pharmacare on to their children. Other premiers layered on the good feeling. Alberta's Ralph Klein said it was a "stroke of brilliance." Newfoundland's Williams enthused about a national vision. At one point, it almost seemed they would burst into a spontaneous

rendition of *Age of Aquarius*, followed by *O Canada*.

Even Quebec Premier Jean Charest's ritualistic assertion that Quebec would continue to run its own plan — while Ottawa would be expected to pay for it — passed with barely a murmur of discontent. CFNU president Silas was in a justifiably celebratory mood. Her organization's short paper had provided the foundation for the most surprising turn in federal-provincial-territorial relations in a decade.

But like any grand plan, the devil is in the details. And this one has potential demons in every nook. First, and most importantly, even a conservative version of the premiers' plan would cost billions more than Ottawa has been prepared to spend. The premiers want Ottawa to pick up the entire cost of provincial drug plans, which totalled \$7.6 billion last year and are growing at more than 10 per cent a year. On the other hand, new federal Health Minister Ujjal Dosanjh was careful to use the phrase "catastrophic drug coverage" when he talked to reporters. Although he never quantified the difference, the Romanow Commission estimated that a catastrophic plan would cost roughly \$1 billion, assuming the feds would pick up the tab for individual drug costs above \$1,500 per year.

Starting off negotiations \$7 billion apart is bad enough, but it may not be the biggest political hurdle for the plan. Provincial drug plans now vary considerably. Most provinces already have better catastrophic coverage than Romanow recommended, while some have none. Even if the feds did assume existing provincial plans, they would still have to come up with new money to cover Canadians currently without catastrophic plans — or cut coverage in the other provinces. However, it's difficult to imagine the reaction of already-volatile

voters if this so-called policy success resulted in massively increased user fees for most Canadians with public drug coverage. Of course, the feds could "level up" coverage to the best anywhere in the country, and the final tab would be more than \$10 billion.

Unfortunately, that's not the end of the cash controversy. The premiers also want Ottawa to cover 25 per cent of overall provincial health-care expenditures with their Canadian Health Transfer (CHT). If drug spending would no longer count as provincial spending, then Ottawa would have to pony up at least another \$2 billion. Finally, the premiers are also unhappy at the equalization program and want another \$3 billion-plus for this item. *Mais oui*, they want all this money without any strings whatsoever.

While the premiers projected unity, discord was never far from the surface. The premiers are bitterly divided on the role of the private sector in health care. Mr. Klein continues to muse about why Canadians can buy other commodities but not new hips. He would like to see more for-profit care within medicare and non-medicare options as well. On the other hand, Manitoba's Gary Doer and Saskatchewan's Lorne Calvert are opposed to for-profit contracting, even if the public pays the bills. Of course, Klein had admitted to the Alberta press corps in June that his own caucus had overturned plans to establish for-profit orthopedic clinics in Calgary and Edmonton. But the national media usually don't keep up with provincial news and Klein played them like a violin, teasing them with his controversial language.

The final communiqué reasserts that all provinces support the Canada Health Act. Unfortunately, given the auditor general's documentation of the

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THE PREMIERS' ANNUAL THEATRICAL PERFORMANCE: CONSENSUS MASKS CONFUSION (continued)

lack of federal oversight and action and the premiers' disagreements, it's pretty clear that this oath of fealty means less and less all the time.

Accountability for federal cash doesn't bother Ontario or the six smaller provinces. They are either ideologically onside or so desperate for funding that they would sing Dixie if the feds promised more money for its performance. Jean Charest has budget problems as well, but can't appear to be any friendlier with Ottawa if he hopes to win re-election. And, with oil touching \$44 a barrel and Alberta's debt almost history, Mr. Klein scorns even the loosest threads of accountability to Ottawa. Forget the tight strings.

Unfortunately, the premiers paid scant attention to the elephant at the health-policy table. Poor-quality care costs thousands of Canadian their lives every year while wasting billions of dollars in

the process. In May, the Canadian Patient Safety Study revealed that 10,000 to 25,000 Canadians die every year from adverse consequences from their hospital stays. In February, an Ottawa group showed that one-sixth of area seniors were readmitted to hospital within 30 days of discharge. Most of these incidents could have been prevented with better and cheaper community care. Adverse effects of prescription drugs kill thousands and hospitalize tens of thousands every year. Too many Canadians wait too long for care, even though most delays can be fixed with better management rather than more money.

To be fair, premiers continue to talk about tactics such as primary health care and home care. But, their reform language is parsed with "more, more." On the other hand, the international literature increasingly recommends that

health systems should focus on continually reducing waste and improving quality, rather than simply cutting or adding money. The true strategy for sustainability should be based upon providers delivering quality, patient-centred care from high-quality workplaces.

The premiers may have stage-managed the Niagara-on-the-Lake love-in, but now they have only a month to prepare for their next performance at the Sept. 13-15 first ministers' meeting in Ottawa. So far, their national pharmacare proposal has dazzled the audience. But, it's unlikely that their masks of consensus will continue to disguise the confusion and controversy seething just below the surface.♦

First appeared in the Winnipeg Free Press, Thursday, August 5, 2004.

ARE THERE HARD DATA ON WAITING LISTS?

The Steering Committee has been watching the waiting list debate during and since the federal election with some concern. To begin to address the data issues, member Irfan Dhalla recently forwarded several references we reproduce here as they may be of interest to others:

1. Robert J. Blendon et al. "Common Concerns Amid Diverse Systems," *Health Affairs*, Vol 22, No. 3, May-June 2003, 106-21, comparing patient experiences in five countries (Canada, US, UK, NZ, and Australia). Exhibit 7 focuses on patient perceptions of waiting lists, and could easily be interpreted to argue that waiting list problems are worse in Canada than in any of the other four countries.

2. Robert J. Blendon et al, "Confronting Competing Demands to Improve Quality," *Health Affairs*, Vol. 23, No. 3, May-June 2004, 119-35, comparing hospital executives' views from the same five countries. Compared to their international counterparts, far more Canadian executives feel that waiting lists have been getting longer over the last two years. However, the executives' estimates of waiting lists put Canada in the middle of the pack.

3. A Statistics Canada summary of the waiting list survey they did can be found at: <http://www.statcan.ca/Daily/English/040630/d040630b.htm>. Seventeen per cent of

respondents nationwide had to wait longer than three months for non-emergency surgery. There were no data on emergency surgery or emergency diagnostic testing.

4. The Western Canada Waiting List Project is a consortium of the western provinces and regional health authorities and has an interesting website with a lot of resources: <http://www.wcwl.org>♦

MRG URGES COLLEGE OF PHYSICIANS AND SURGEONS TO ELIMINATE BOUTIQUE MEDICINE

Steering Committee member Irfan Dhalla has been monitoring the development of policy on block fees at the College of Physicians and Surgeons of Ontario and on July 19, 2004 sent the following letter to College President Dr. Barry Adams summarizing our concerns with the draft policy, set to come up for discussion in the fall of 2004.

Thank you for writing to Dr. Gordon Guyatt asking for input into the draft policy on Block Fees. The Medical Reform Group is responding to this request on behalf of Dr. Guyatt, and other members of the MRG steering committee.

The MRG congratulates the College on taking on this review, and on developing stricter guidelines regarding block fees. The MRG is, however, disappointed that the College has not decided to take what we believe is the appropriate action, which is to ban block fees altogether.

The fundamental reason the College should ban block fees is that whatever regulations the College establishes for block fees, there will continue to be numerous violations of the regulations. Continued violations are inevitable because adherence to the proposed regulations would require a patient to either challenge a physician in his or her office or to complain to the College.

Physicians will be able to violate the regulations with impunity because patients will not challenge physicians' practices with respect to block fees, and will not report violations to the College. The reasons patients will not challenge physicians' practices with respect to Block Fees or report violations include the following:

1) Patients will be unaware of the regulations.

2) Clinicians will choose to interpret the regulations as being consistent with their current practices, which in many cases will violate the new regulations (and indeed, at least the spirit of the old ones). The very unusual patient who

does make an inquiry is likely to be reassured by the physician (or the physician's support staff) that the block fee is in adherence to the College guideline.

3) Patients are in an extremely dependent position with regard to their physicians. Very few patients will feel comfortable challenging their physician's practices with respect to block fees because of this dependent position.

4) The extreme shortage of primary care physicians in Ontario at the moment substantially increases patients' dependency. Many Ontario citizens now feel grateful if they have a primary physician at all, and are even more unlikely to challenge practices because this increased vulnerability.

5) Those for whom block fees are most problematic, the poor and elderly, are least likely to have the knowledge, skills and confidence necessary to challenge physicians' practices with respect to block fees, either in the office or in a formal complaint to the College.

As a result of the certainty of practices in violation of the new guidelines continuing, we strongly advocate that the College ban block fees, and aggressively advertise the banning of block fees to physicians and to the general public. The banning of block fees will be a policy that the public will be able to understand. The regulations as proposed will not.

Should the College reject the MRG's plea to ban block fees, the College must do all it can to minimize the violations of the new standards that will inevitably persist. With respect to the document itself, the following may help to minimize violations:

1) In terms of the principles, the statement should deal with not only the magnitude of the fee, but the form in which the fee is charged. This is obviously critical to the issue of block fees. The factors that the physician should consider are not only the nature of the service provided and the ability of the patient to pay, but the patient's dependent relationship on the physician.

2) The document should specify that physicians cannot charge patients for the more conscientious provision of an insured service, or for assuring greater availability of the physician to provide an insured service. To be specific, clinicians should not be able to charge for working harder to gain rapid consultation or testing, or ensuring round-the-clock availability, or ensuring longer appointments and more attentive responses. To be absolutely clear, the document should include examples of such current practices that should be clearly specified as unacceptable.

3) The provision that a physician must not offer to provide preferential services to a patient who agrees to pay a block fee should certainly be included.

4) The practice, highly publicized in the Globe and Mail and the Hamilton Spectator, ...of charging large annual fees of over \$1,000 for services including "a detailed medical workup," "a customized health care plan," and "24/7" access should be explicitly labelled, and explicitly banned. This kind of practice has been referred to in the United States as "boutique medicine" or "luxury primary care."

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MRG URGES COLLEGE OF PHYSICIANS AND SURGEONS TO ELIMINATE BOUTIQUE MEDICINE (continued)

Boutique medicine allows physicians to aim for practices with 150 patients each, rather than the customary 1500 or so. It is not sufficient to include provisions – as the current document does – that if appropriately interpreted will lead to the termination of boutique medicine. It is highly likely they will not be appropriately interpreted. Thus, the explicit labelling of this form of practice, and clear statements of its unacceptability, are absolutely necessary.

5) A major omission of the revised policy is that it does not specify a maximum allowable block fee. This fee should reflect the value of non-OHIP services included in the block fee (for example, telephone advice, telephone prescription reviews, form completion, etc.) and should be no more than \$100.

6) The regulations should specify that doctors who offer patients the block fee option are required to post in their office a CPSO-designed poster outlining what services cannot be included in the block fee, and specifying that boutique medicine is a violation of professional conduct. This poster should be in a highly visible location and should also explain how patients could file a complaint if they feel their doctor is violating the policy.

To minimize the likelihood of violations, once the new regulations are in place, the College should organize a campaign to inform both physicians, and the public, of the new regulations. The College should make an effort to immediately notify those known to be practicing boutique medicine that their current practice is professional misconduct. The public aspect of the media campaign will be most effective

if the College recruits partners in the effort to get the word out. Such partners could include the government of Ontario, and the Medical Reform Group.

In summary, the Medical Reform Group believes that the CPSO should ban block fees. If block fees continue to be permitted, we suggest modifications to the new proposed block fees policy. The MRG further recommends that the College inform all Ontario physicians of the changes, ensure that those physicians currently known to be violating the new policy are fully aware of their misconduct, and aggressively inform the public of the changes.

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

PHARMACARE IN THE PUBLIC INTEREST

A discussion of pharmacare must not deflect attention away from an essential issue that divides premiers, namely, the need to curb the privatization of health care services in Canada. The key condition for federal funding must be a prohibition on using public funds to privatize the delivery of health care services. Health care belongs in the public and not-for-profit sectors, not in the hands of unaccountable private investors.

A national pharmacare plan must not come at the expense of the other constitutive elements of a sustainable national health care system. This briefing note has been prepared to discuss the elements of a pharmacare plan in the public interest, as opposed to a plan in

the interests of the pharmaceutical and insurance industries.

The Canadian Health Coalition's key message and recommendations have not changed. Medicare is sustainable, for-profit care is not. The federal government must secure the long term financial stability of Medicare and buy the changes needed—including public coverage for essential medicines--by restoring long term funding and enforcing the criteria and conditions of the *Canada Health Act*.

The Premiers' Action Plan for Better Health Care issued on July 30, 2004 is focused almost exclusively on a National Pharmacare Program. It calls for the federal government to assume full responsibility for pharmacare across

Canada and leave everything else to the provinces. Provincial governments like Alberta, Quebec, Ontario and B.C. would be free to privatize all the other components of national public health care (hospitals, diagnostics, elective surgeries, home and long-term care...)

Pharmacare is an important element but only one of several constitutive elements needed to sustain and expand public health care across the country. Canadians do not want a Pharmacare plan if it undermines the other elements of the national health care system. (See the CHC Briefing Note "*Medicare is sustainable, for-profit care is not*," and the list of 8 recommendations to ensure Medicare's sustainability.

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PHARMACARE IN THE PUBLIC INTEREST (continued)

National Objectives of Pharmacare in the Public Interest

The goals of a national pharmacare plan in Canada should be:

1. Equity of Access
2. Safety and efficiency
3. Cost containment

It is time to extend the principles of Medicare and the Canada Health Act to essential medicines. Currently, Medicare covers less and less as care is shifted out of hospital settings. Millions of Canadians are denied access to essential medicines when they need them because of financial barriers.

Canadians currently have for drug delivery what the Americans have for medical care. It's a mix of public and private payment instead of a single payer; it is not universal but inequitable and dysfunctional. Patents and pharmaceutical profits are protected instead of the sick and the poor. The current system is designed to drive up drug sales and profits--regardless of health outcomes. Access to new and expensive treatments is limited to those who can afford them. This approach to medicine is unethical and unsustainable.

Economically disadvantaged segments of society and entire regions of the country are suffering because of this U.S. style approach to medicine. The problem will get worse if Canada continues to encourage monopoly drug patents on pharmaceuticals and biopharmaceuticals. As an illustration of the perverse effects of the federal approach to health as a commodity to be commercialized--a drug company is now charging \$3,850 per person for a genetic test for breast cancer. There is wealth creation. But what about treating the sick.

Pharmacare in the public interest would lower overall drug

costs, provide universal coverage to essential medicines and improve prescribing practices. Access to essential medicine is a human right that takes precedence over intellectual "property rights" and wealth creation for pharmaceutical giants.

To ensure equity, appropriateness and sustainability for a national pharmacare plan, cost control measures are essential. These include drug patent reforms, strict controls on drug marketing, promotion, dispensing fees, bulk purchasing, and paying only for what works safely and is cost-effective.

10 Elements of Pharmacare in the Public Interest

1. Universal Public Drug Insurance Plan

- first dollar coverage; no user fees, co-payments or premiums
- fully public insurance plan to control costs (no private "partnerships")

2. National Formulary for Essential Drugs

- use WHO list of 329 essential drugs as a model, with decision on inclusion based on evidence of efficacy, safety and comparative cost-effectiveness (More than 5,000 drugs are marketed in Canada)
- formulary committee to make allowance for special needs
- bulk purchasing with bargaining power to reduce prices

3. Patent Reform to End Abuses

- access to essential medicines has primacy over monopoly drug patents
- change current regulations and prohibit 'evergreening' of patents

4. Safety and Transparency Paramount in Drug Regulation

- replace Health Canada's Therapeutic Products Directorate with an accountable and transparent regulatory agency--free of conflict of interest
- proper safety warnings in plain

language which list possible alternatives to taking the drug where appropriate

5. Enforce the Ban on Consumer Advertising of Prescription Drugs

- institute adequate sanctions to prevent prescription drug advertising aimed at the public, and establish strict rules governing industry promotion and marketing to health professionals

6. Accountable and transparent Decision Making

- public plan pays only for what works, not for useless, dangerous, or unnecessarily expensive new drugs;
- public access to all information upon which decisions on drug approvals and financing are made, including pre-clinical and clinical data

7. National Prescribing Service

- integrate support for appropriate drug prescribing into health care system
- work through College of Physicians and Surgeons, College of Family Physicians

8. Establish Public Drug Information System

- independent comparative information on drug and non-drug treatments
- fund pharmacists to run a medicine information line

9. Systematic Follow-up of Treatment Outcomes

- compulsory adverse reaction reporting by physicians

10. Regulations for Ethical Conduct in Clinical Trials and Research

- monitor and enforce national rules for ethical conduct in clinical trials and health research ♦

This fact sheet was released by the Canadian Health Coalition August 23, 2004.

CAN WE GET NATIONAL PHARMACARE NOW?

Joel Lexchin summarizes the issues around national pharmacare for a recent e-mail list

My reading is that Romanow rejected the plan for two reasons. First he sees this as an attempt by the provinces to off-load a huge expenditure on the federal government - no provincial sharing of responsibility. Second, he is worried about the overall cost of the proposal.

The response below is largely about the economics of a national pharmacare plan not the politics. The problem that the feds face is that if they offer a cost-sharing program then the provinces would reject it because of past experience with federal provincial cost sharing programs in health care - i.e., unilateral changes by the federal government.

The feds are very unlikely to agree only to change programs with the consent of the provinces since this would give up too much control. That's probably why Dosanjh is only talking about a catastrophic program. It only commits the federal government to a limited expenditure.

There are probably a couple of solutions to this problem. One is simply to offer a 50-50 cost sharing program to the provinces. For provinces that sign on to this program all drugs covered would be bought by a single purchasing agent. If the government was aggressive enough this could lower prices by probably 10 to 20 per cent. The lower prices plus the universal coverage might create enough public pressure to force the provinces to sign on.

A second possibility could be the federal government running the program but using progressive premiums to finance some of the cost. Third would be a federal program that only pays for a list of "essential drugs" that would be developed by an independent medical committee. If the provinces wanted coverage for things outside these essential drugs that would be up to them.

Under a first-dollar national pharmacare plan overall drug expenditures would be less than they currently are even allowing for increased use because there would not be any direct charges to patients. The savings would come from lower administrative costs (large provincial plans like the ones in Ontario and Quebec have administrative costs of 2 to 3 per cent versus commercial plans costs of 8 to 9 per cent) and lower purchasing costs. However, the latter would require the federal government to take an aggressive stance in bargaining with the drug companies in order to get lower prices.

Australia does this and achieves prices on new drugs that are about 9 per cent lower than ours. Without aggressive bargaining by the government a national Pharmacare plan would be a profit bonanza for the pharmaceutical companies - larger markets and same prices. However, aggressive bargaining is not the only thing that would be necessary. The idea that a Pharmacare plan should only cover essential drugs is a good one but I think that for a wealthy country like Canada the WHO essential drugs list would probably be too restrictive -- it could leave people with uncommon diseases without coverage since drugs for these conditions tend to be relatively expensive and aren't included on EDLs.

We would require a national formulary committee to come up with a list of drugs to be included plus there would have to be some kind of allowance made for people who genuinely need products that are not on the formulary. Another aspect that would have to go along with a national Pharmacare plan is a program to promote appropriate prescribing. Such a program might generate considerable friction with the provinces since it might be considered interference with the practice of medicine and would therefore be intruding on provincial toes. One approach might be for the federal government to fund a National Prescribing Service (similar to the one in Australia)

that would then work through the Royal College of Physicians and Surgeons and the College of Family Physicians.

Finally, of course, aside from the financial aspects of a national plan there is also the question of equity. Right now there is very little of it when it comes to drug insurance: out-of-pocket expenses for the elderly vary wildly depending on what province you live in. The working poor tend to lack coverage in almost all provinces and even in Quebec where they get coverage there are huge copayments. Private drug insurance is actually a regressive form of taxation. Under Canadian tax legislation the portion of health insurance that is paid for by the employer is tax free. By subsidizing insurance through the tax system, the value of the subsidy depends on the person's marginal tax rate. What this means is that the more you make the larger your subsidy. According to Marc Stabile, an economist at the University of Toronto, the subsidy for someone in the highest 20 per cent income bracket is 3 times what it is for someone in the lowest 20 per cent income bracket.

Canada long ago rejected the idea that there should be a difference in coverage for hospital and doctors' services and we got Medicare. However, when it comes to outpatient drugs we have adopted the American model of coverage for some but not others, deductibles and copayments. If we look south of the border we can see what the consequences of this model are for the American health care system.

To those who say that none of the countries that have drug insurance have first dollar coverage there are a couple of answers. In England, although there are copays there are also broad exemptions from the copays such that 80% of the prescriptions written are exempt. Wales is going a step further and will eliminate all copays by 2007. It can be done if the politicians have the gumption to act.... ♦

IS THERE A LOGIC TO DELISTING?

Ahmed Bayoumi summarizes the issues discussed in a recent Steering Committee review of yet another round of delisting of procedures from the OHIP fee schedule.

The Ontario budget of May 2004 removed three services (chiropractic services, physiotherapy [except for seniors through homecare and long-term care facilities], and routine eye examinations for people 20 to 64) from the list of insured services under the OHIP, effectively privatizing these services. A reasonable expectation is that these services will be readily available only to individuals with supplementary health insurance, usually through their place of employment, and those wealthy enough to pay out of pocket. People without extra insurance or ready cash will simply have to go without.

The latest items to be delisted can be added to a now lengthy list of services that were once covered by health insurance plans but no longer are, including reversal of sterilization, general anaesthesia for uninsured dental procedures performed in hospital, routine newborn circumcision, removal of tattoos, repair of deformed earlobes resulting from use of pierced earrings, removal of acne pimples, injection of varicose veins, otoplasty to correct outstanding ears, removal of benign skin lesions, removal of port wine stains in adults, in vitro fertilization, weight loss clinics, travel assessments, immunization clinics, insertion of testicular prostheses, penile prostheses and intracorporeal injection for erectile dysfunction, and others.

In looking at this list, several questions come to mind. Does delisting make sense? What are the criteria for removing elements from the list? What process should be used in deciding what to insure and not insure?

Does delisting make sense?

We believe a periodic review of what is and is not covered under the

health insurance system is eminently reasonable. The circumstances under which insured services were once deemed appropriate for coverage under the health insurance plan are never constant – technology advances, new evidence about effectiveness accumulates, prices of services change, and the available budget for health care may increase or decrease.

It would be irrational and unfortunate if coverage decisions could never be revisited. So, as a general principle, it makes sense to look at the services and consider adding some and simultaneously removing others. Indeed, at the same time as the budget delisted some services, it listed three new immunizations for chickenpox, meningitis and pneumonia.

This coupling of delisting old services and listing new ones leads to the second question – what are the criteria for removing elements from the list?

Are they the same as the criteria for adding new services? The health services literature has several guidelines for what should or should not be covered, including considerations of cost-effectiveness (the amount of money spent relative to the amount of health obtained), equity (providing health care to those who need it most), and medical necessity (defining what is needed to maintain health and deciding coverage decisions on this basis).

Unfortunately, the criteria by which listing and de-listing of services are conducted is unclear. The government has promised a “more transparent and accountable” budget and committed itself to a process of priority-setting. The government’s Town Hall budget consultations state that citizens recognize

that some activities “would be eliminated or done by others to free up funds to reduce the deficit or to invest in new and better ways of delivering public services”.

Yet the process of prioritizing what should be covered by the provincial health care plan is much more complex than this simple statement suggests and involves a number of considerations including efficient use of resources, the magnitude of health gains, and the distribution of benefits.

Is there any evidence that such considerations are considered in coverage decisions?

The delisted services enumerated above generally share two considerations. First, many of the issues they address are considered relatively minor or discretionary (such as travel clinics) or may seem to be more “lifestyle” and less strictly “health” issues (such as cosmetic surgery). Yet this classification has two significant limitations.

First, some people may have significant concerns about classifying some issues as minor or non-health-related – such as infertility. Second, the health of individuals who use the services can be very heterogeneous. For example, some individuals who may potentially benefit from physiotherapy may have minor aches whereas others could be in severe pain. A disturbing observation is that these considerations are more relevant for the recently delisted services.

The second, and more troubling, criteria that delisted services seem to share is that they are politically

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IS THERE A LOGIC TO DELISTING? (continued)

expedient. Most insured services in Ontario are delivered by physicians – a group in active negotiations with the government regarding the fee schedule when the budget was tabled. Notably, none of the three recently delisted services are delivered by physicians. Together, these observations raise the worrisome suggestion that the government delisted services according to what they could get away with, rather than according to criteria that flowed from a priority setting exercise.

If the current process is opaque, and perhaps open to political manipulation, is there an alternative?

What process should be used in deciding what to insure and not insure? We believe the following considerations are important when considering what services to remove from the insurance list:

- **Examine the evidence base for a service's effectiveness and cost-effectiveness.**

We believe a decision about what to insure should be evidence-based, including data on both clinical effectiveness and economic efficiency. A rich field of technology assessment exists for synthesizing evidence, identifying priority areas for future research, and evaluating the costs relative to the effects of the interventions. We believe such information is a necessary prerequisite for coverage decisions.

- **Establish priority-setting exercises that assess public values in meaningful ways.**

Determinations of effectiveness and efficiency are insufficient for

decision making without also considering the values Ontarians have with regard to how services are distributed. For example, Ontarians may accept having some less efficient services insured if they promote health equity gains. Yet vague discussions about core values are unlikely to be helpful. Instead, priority setting exercises need to be detailed and tackle difficult tradeoffs. Such consultations need to be explicit about *which* values are important to Ontarians and *how* these values are reflected in insurance decisions.

- **Establish a transparent public process for decision making.**

The process for decision making should be open, accessible, and free from undue influence by any particular group of providers. The best way to ensure this is to establish an independent advisory committee, with broad representation from community members and experts, which will issue recommendations to the minister about appropriate services to be listed.

- **Incorporate mechanisms that address coverage in exceptional circumstances.**

The services most recently delisted share the characteristic that affected individuals do not fit a 'typical' pattern. For each service, it is easy to imagine an individual for whom the service represents a major health service which they will have to do without. Although there is a limited and cumbersome mechanism of appeal for asking OHIP to insure otherwise uninsured services, a better mechanism for dealing with individual reviews for exceptional circumstances will become

necessary if services to be delisted have implications for a broad-based population.

A precedent for most of these criteria already exists – insurance of drugs under the Ontario Drug Benefit Formulary. Drugs are considered after an impartial committee evaluates the evidence and makes recommendations to the minister. Appeals for uninsured drugs are handled through individual requests (Section 8) mechanisms. While the ways in which decisions are made are not always clear, the process for deciding about insured services could be even more transparent than that for drugs, since the proprietary rights of patent holders (such as drug companies) are rarely at issue when considering coverage decisions.

Delisting may be occasionally necessary – and sometimes desirable – to have a rational and efficient health insurance system. Nevertheless, delisting will often be viewed as a loss and, given the natural aversion to such situations, may be politically difficult. The worst delisting decisions will be those that are seen to be politically expedient rather than principled.

The MRG believes that establishing criteria to consider listing of services and incorporating broad public input will help improve the quality of the decisions that are made. How do the most recent decisions stack up against our criteria? It's impossible to say without taking the time to evaluate the evidence and consider Ontarians values. It seems clear, however, that the process of deciding what is insured under OHIP is in need of reform.♦

PUBLIC HEALTH AND WOMEN'S REPRODUCTIVE HEALTH RIGHTS

Rosana Pellizzari

Women in many parts of the world lack access to basic sexual and reproductive rights. This is something with which I have had first hand experience, the most recent, a three month field placement with the Centre for Research in Women's Health, University of Toronto, and the Centro de Investigaciones en Estudios de la Mujer, Universidad de Costa Rica (CIEM) in San Jose, Costa Rica.

From January 3rd to March 31st, my work on the issues of violence against women, sexual assault and access to emergency contraception served as a reminder of how important it is to take a human rights approach to basic public health issues such as women's access to health care. Lack of access, whether secondary to economic, geographic, religious or social barriers, translates to lack of choice for women in Costa Rica and elsewhere.

Although Costa Rica is one of the more prosperous and stable countries in Central America, it is politically conservative and still dominated by the powerful Roman Catholic Church, which managed to establish a foothold in the country's constitution. It is this foothold that has shut down the country's in vitro fertilization program, eliminated the Ministry of Health's sexual education program, banned abortion, and prevented the introduction of emergency contraception (EC).

Although the International Federation of Gynecologists and Obstetricians (FIGO) has made it clear that is unethical to deny victims of sexual violence treatment with EC, physicians in Costa Rica are fearful that, by prescribing EC to women, they will be found guilty of breaking existing laws that guarantee protection to all unborn children from the time of conception.

Since the 1860's, the Roman Catholic Church teaches that life begins at the time of union between sperm and ovum. To interfere with this process is to potentially breach constitutional law in Costa Rica.

A recent study funded by the Pan American Health Organization found that none of San Jose emergency department workers had provided sexual assault victims with EC. To fill this gap, national non-governmental groups have trained 911 operators to refer victims to NGOs rather than hospitals for information on how to access EC. Since a dedicated product is not currently licensed in Costa Rica, women must purchase birth control pills and follow the "Yuzpe" method.

Not as effective as Levonorgestrel and associated with more side effects, the Yuzpe method involves taking two doses of 2-4 oral contraceptives 12 hours apart. However, to many Costa Rican women, the cost of purchasing an entire package of Ovral, or it equivalent, is prohibitive. Recent Canadian consensus guidelines published by the Society of Obstetricians and Gynecologists of Canada recommend Levonorgestrel, and not Yuzpe, as the drug of choice for EC. A review of the published research shows that Levonorgestrel can be taken in one dose, rather than two, up to 120 hours after unprotected intercourse.

By the end of January, I had joined the emergency contraception (EC) workgroup (a coalition of government and non-governmental representatives) and assisted with the development of a position paper on EC in Costa Rica. A meeting with the Minister of Health on February 2nd to discuss a national strategy and gain approval led to approval to hold a forum for key stakeholders on March 24th, 2004. Given the Ministry's agenda to promote sexual rights and

introduce new legislation later in the year, increasing access to EC gained the informal support it needed to get it on to the policy agenda.

Although physicians in Costa Rica were not prescribing EC, opportunities existed to promote its use. Costa Rica's Planned Parenthood association is committed to using its international connections to bring a Levonorgestrel product to market. Neighbouring countries such as Nicaragua and the Dominican Republic already have a fairly inexpensive product available. In addition, women can purchase oral contraceptives from pharmacists in Costa Rica without a doctor's prescription.

Here in Canada, only a handful of provinces have made Levonorgestrel available "behind the counter". Health Canada announced earlier this year, its intention to make Levonorgestrel available to all Canadian women without prescription, through pharmacists. Research headed by Sheila Dunn here in Ontario has shown that young women will access EC quickly and effectively from pharmacies, if directed by a 1-800 hotline to an open and participating pharmacy in their community.

Awareness of EC in Costa Rica, although growing, is limited. University students comfortable with using the internet are beginning to request it. In preparation of the national forum, links to the Latin American Coalition on Emergency Contraception, International Planned Parenthood, the Costa Rican national society of Obstetricians and Gynecologists, and the University of Costa Rica were cultivated and

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PUBLIC HEALTH AND WOMEN'S REPRODUCTIVE HEALTH RIGHTS (continued)

strengthened. Toronto's Dr Sheila Dunn agreed to attend the forum and assist with physician meetings at three of the four hospitals in San Jose.

During the week of March 22nd to March 26th, Dr Sheila Dunn and I held hospital rounds with physicians, conducted a training workshop for providers working with students and presented at the National Forum on Emergency Contraception. Following the forum, the Minister of Health requested a briefing document on EC, which we helped Ministry staff prepare and submit on March 29th.

What was instrumental in moving the agenda forward was the fact that I was a physician. As an international expert, Dr Sheila Dunn was extremely valuable in using her expertise and credibility to dispel myths and build confidence. The University of Toronto had, in its partnership with Costa Rica, an excellent opportunity to support the ongoing work of institutions to plan, implement and evaluate inter-sectorial efforts to protect women from

violence and strengthen the health sector's response.

Unfortunately, the Centre for Research in Women's Health has just recently made a decision to discontinue all its international work and the Costa Rican project, among others, is on the chopping block. For the University in Toronto, as for Canadian women, sexual rights are a given, and access to care is more or less guaranteed. That is not the case for women in Costa Rica. The recent decision is particularly lamentable, given how little of current international research is spent on matters that are of importance to poor women and children.

Back home, I find myself working in rural Ontario. A recent article about me in the Listowel Banner prompted the local Right to Life to write a letter to the Editor, denouncing my position on emergency contraception and asserting that EC is dangerous and unsafe.

The lies and distortions are almost, word for word, identical to those being propagated in Central America. But at least in Canada, women have a choice and Levonorgestrel is available to those

who need it. Many public health units will provide it at subsidized prices, or even free to women who can't afford to purchase it. But, for women in towns too far from a clinic, or too small for a pharmacy, EC remains inaccessible.

Public health units have a major role to play to bridge those access gaps, particularly for young women who face even bigger barriers. Sheila Dunn's work has demonstrated that if young women are assisted in accessing post-coital contraception in emergencies, pregnancies and abortions can be prevented.

A hotline, pharmacies open 24 hours, public health nurses, proactive physicians who provide all their contraceptive patients with advance prescriptions for Levonorgestrel, or even better, Health Canada's proposal to amend the Food and Drug Regulations – Schedule 1272 regarding Levonorgestrel to make it a non-prescription product are all important pieces of an effective strategy. At least here in Canada, preventing pregnancy is not an illegal act. For that, we should all be grateful. ♦

NEW BOOK ON SOCIAL DETERMINANTS OF HEALTH

We recently received the following notice from Dennis Raphael, health policy professor at York University, for a new collection of articles entitled ***Social Determinants of Health: Canadian Perspectives***.

The collection, featuring Pat Armstrong, Andrew Jackson, Michael Rachlis, Martha Friendly, and many others, summarizes how socio-economic factors affect the health of Canadians, surveys the current state of

eleven social determinants of health across Canada, and provides an analysis of how these determinants affect Canadians' health. In each case, the book explores what policy options would contribute to better health outcomes, and how to ensure that these options are pursued.

Eleven critical areas are investigated: Aboriginal status, early life, education, employment and working conditions, food security, health care services, housing, income and its

distribution, social safety net, social exclusion, as well as unemployment and employment security. Gender, and how its meaning is constructed within Canadian society, is another important social determinant of health. All contributors systematically consider how it impacts upon and interacts with their specific social determinant of health to influence health.

The volume is \$45.95 from Canadian Scholars' Press in Toronto. ♦

ALL OUR CHILDREN

Anne Mullens

How a research project in his own backyard turned one health researcher into a social activist. If a virulent microbe was making children sick and undermining their health for the rest of their lives, everyone would expect the leading scientific expert in the field to become an activist to eradicate the bug.

That's the analogy British Columbia epidemiologist Clyde Hertzman uses to explain his transition from detached health researcher to social activist – only in his case the “bug” isn't an infectious microbe, it is early childhood experiences and their impact throughout life.

“It is a bit more political than dealing with an infectious agent where you are convincing surgeons to wear masks or people to wash their hands,” says Dr. Hertzman, a professor in the department of health care and epidemiology in the University of British Columbia's faculty of medicine. “The logical outcome of my research is to talk about how we structure society and whether we can alter social arrangements that could improve the lives of kids in those early years.”

Dr. Hertzman, 51, has long specialized in the social determinants of health – how factors like income, education, employment and upbringing affect how healthy we are. In particular, Dr. Hertzman has become internationally renowned for his work in early childhood development. He pioneered the concept of “biological embedding,” where biological factors of early childhood fuse with the social and psychological factors to influence a person's health into the adult years. He directs the Human Early Learning Partnership (HELP), an interdisciplinary network of early childhood development researchers from B.C. universities, and holds a Canada Research

Chair in Population Health and Human Development. He is also a fellow with the Canadian Institute for Advanced Research.

These days he finds himself overseeing a busy research agenda while donning the cap of social activist to help change B.C. communities, especially to improve their social programs and neighbourhoods in ways that enhance early childhood development. While those dual roles might make some academics uncomfortable, to Dr. Hertzman it is a natural combination and one that gives his research focus and application.

Usually social science researchers comment on what they observe, but they rarely take their research to the next level – designing research programs to specifically gather evidence that can be used to fuel change. Dr. Hertzman's team gives community workers the kind of evidence-based information that allows them to plan strategically and “make the right changes,” he says.

Earning degrees in medicine, community medicine and epidemiology from McMaster University in the 1970s, Dr. Hertzman has been at UBC since 1985, researching the socioeconomic and psychosocial factors that influence people's health.

In January 2001, however, one specific project caused Dr. Hertzman's life to change dramatically and completed his metamorphosis into a bona fide social activist for early childhood development. For a year he and his research team had been working on the Vancouver Early Childhood Development Mapping Project.

The research entailed asking all kindergarten teachers in the Vancouver School Board to complete a checklist questionnaire, called the Early Development Instrument, to assess the children in their classroom based on whether they were ready to learn. The

questionnaire didn't identify individual children, but rather measured the group as a whole on physical health and well-being, social competence, emotional maturity, and language and cognitive development. Amazingly, some 97 percent of the teachers responded and completed the questionnaire.

Dr. Hertzman's team analysed the results, comparing the “learning readiness” factors to characteristics such as income level, affordability of housing in the area, neighbourhood crime rate, the number of parks, playgrounds, libraries and childcare options, and other measures of social cohesion at the neighbourhood level. The researchers then plotted the results on maps of the city. The maps revealed distinctive relationships between the level of school readiness in children and the characteristics of the neighbourhoods they lived in.

The team concluded that not only do parental income, education and parenting style have a strong influence on whether children are ready for schooling, but that neighbourhood characteristics do, too. For example, areas with a variety of good resources for children – libraries, playgrounds, preschools, child care, community centres and enrichment programs – correlated to better-adjusted children who were more prepared to learn.

Not surprisingly, the proportion of children identified as less ready for school increased dramatically as one moved from the most affluent west-side neighbourhoods to the poorest east-end parts of Vancouver. But while the biggest proportion of vulnerable children were in the poorest neighbourhoods, in fact the biggest

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ALL OUR CHILDREN (continued)

number of vulnerable children were spread throughout the city's large middle-class sections. That, says Dr. Hertzman, is "a vitally important finding," because "if you concentrate all your energy in the least-advantaged group, then you miss the majority of kids who are developmentally delayed."

The maps were published in January 2001 in the Vancouver Sun. And his phone hasn't stopped ringing ever since.

"It created a huge response because people could see the information so clearly, and it represented their children in their neighbourhoods, rather than a random sample of the population in a hypothetical neighbourhood," says Dr. Hertzman. "They were the parents, the school officials, the neighbourhood planners, the politicians – it created a level of interest that was way beyond normal."

Suddenly he was deluged with requests to speak to a wide range of groups, not just to fellow researchers, but to school boards, Rotary Clubs, Chambers of Commerce, various city officials and various ministries in the provincial government. Before the newspaper story, "we pretty much had to beg the school board to let us do the research," he says, but after the piece ran in the Vancouver Sun, all the school boards in the province wanted him to examine their schools and neighbourhoods and were offering the research money to conduct the studies.

Over the last three years, Dr. Hertzman and his teams have mapped the school readiness of all kindergarten children in more than 60 school districts across B.C., creating a database on how children are developing in every neighbourhood in the province.

"The biggest part of the lesson to me is that, from an academic standpoint, the journals and other academics don't care if you are dealing with random samples rather than real children in real neighbourhoods. But the world cares. By switching over to what the world cares about we have been able to create information bases that actually lead to structural advances and not just casual interest among scientists."

Dr. Hertzman finds that the public concern has given his work new impetus, more sources of funding and more interest from other researchers, particularly PhD students who want to do this kind of applied research.

"No research granting agency would ever fund you to do the same research project, over and over again, in 60 different communities. But now that we have this database, we have PhD students lining up to do secondary research on a whole range of things with traditional research funding."

For Dr. Hertzman, a father of three grown children, there has been very little downside: "Not only are you creating a research environment that supports social change, but you are creating an environment where young researchers can do their best work, with more resources, more opportunities and more credibility."

And not surprisingly, over the years his findings directly influenced his own parenting style, particularly in the interplay between "nature and nurture." "The key corollary of my work is that for every child there are environments and experiences which will give them the best chance to thrive, but they will be different for different kids. As a result, we've been careful to tailor each of our children's early opportunities to their aptitudes and vulnerabilities." ♦

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CATHY CROWE-- PROGRESS REPORT

In the spring of 2004, Cathy Crowe received the Atkinson Economic Award which permits her to pursue, for up to three years, my passions for nursing and working on homelessness and housing issues. We've excerpted some items from her August 2004 newsletter, which attempts to report on the situation as she sees it and stimulate discussion.

A rising sense of depression

Iraise this topic with tentativeness, but it's important that we talk about it openly. I have noticed how depressed, both physically and psychologically, organizations working for the homeless have become. This is not the fault of any one of us, but it is now a fact of life.

Many organizations serving the homeless started in the last two decades. They assumed they would be doing good work for a season or two and then the crisis would be resolved. As we know, what has happened instead is that the problem has intensified and many organizations - ranging from Out of the Cold to more formal social agencies - are serving two or three times the number of people that they started with.

These agencies often got underway in whatever space they were easily able to find, such as churches or other space that no one else was using. The facilities were old to begin with and often in poor condition, and they have only gotten worse. The applications that are now being made to improve these facilities with limited grants from the federal government (through the Supporting Community Partners Initiative, SCPI, or "Skippy" as it is called) are for changes like installing better toilets, improving floors, making the heating function and so forth. The result is that space which was in the first place only second rate, is being patched together. *It feels depressed.*

This can be seen in every kind of agency helping the homeless. Daytime drop-in centres, for instance, are overflowing. Not only are more people using the services provided but they have

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CATHY CROWE--PROGRESS REPORT (continued)

higher service needs. Often these agencies find they do not have enough staff resources or physical resources on a day by day basis. For example, many agencies are not able to provide enough food, both because of limited food budgets and because of the huge demand. The crisis which includes crowding and scarce resources results in trauma of various kinds – frustration, frayed tempers, and increased violence. *It feels desperate.*

Added to these burdens on agencies is the fact that certain aspects of the community create pressure (aka NIMBYism) around these facilities to try and contain their activities. It is as though the organizations that are trying to help the homeless get the blame for the existence of the problem rather than being lauded for trying to respond to it. *It feels insecure.*

These conditions lead to vicarious trauma, not only for homeless people using the services but also for staff. Many staff who have been working in homeless facilities have been doing so for much too long and understandably, the burnout rate is growing. Because of the increased workloads and day to day crises, workers are less likely to be allowed to engage in community-wide activities or actions which would help press decision makers for change. Their political voice is minimized.

This means that the kind of mutual support and solidarity that develops among staff and organizations at community mobilizing events is harder to create. Worse, the organizations that serve the homeless perceive that they are no longer able to participate in certain types of advocacy because it may be seen as a risk to their funding, to their non-profit status, to their reputation. *It feels like we're silenced.*

These are difficult long term problems which we never thought would exist, but which we have seen grow as the disaster intensifies. The homeless have become a sizeable underclass in our cities and towns, a group of individuals who have no sense of privilege and whose sense of hope is disappearing. No wonder

there's such a growing sense of depression. *It is depressing.*

Depression in many cases actually impairs cognitive abilities – it becomes much more difficult to think clearly and coherently. Choices seem more limited. There is a rising sense of desperation. Sometimes it can prompt individuals or groups to lash out inappropriately or unwisely. Depression and vicarious trauma impede our collective struggle for solutions.

Many people with experience believe that the best “cure” for depression is, when possible, to get engaged and become involved. Taking concrete action, even on a small scale, can be the best medicine. While depression often prompts individuals or groups to become disengaged, the simple truth is that the best response for this type of systemic depression is to get active. Therefore, even small, local initiatives can be very therapeutic in that they may help people to move beyond the depression to action and solutions

We've faced difficult times in the past and engaged in terrific solutions that mobilized Canadians and led to major funding initiatives – the Rupert Hotel Coalition, the Toronto Coalition against Homelessness' cry for an inquest into freezing deaths, the 1998 declaration by groups across the country that homelessness qualified as a national disaster. There are many more!

Health care expenditure: opportunities for affordable housing.

Here's a truism: housing is a determinant of health. Poor housing leads to poor health, just as better housing can lead to better health. Those who are homeless incur very significant medical expenses. In Canada, where health care costs are mostly borne by the public, it makes sense to ensure there is good housing in order to minimize health care costs.

We are currently in the midst of a massive political debate about health care costs, and there's a summit of provincial

and federal leaders scheduled for mid-September. The provincial premiers talk about the need for more money to be devoted to health care, and the federal leaders seem to agree, although they are sure to differ on the amounts and/or the conditions.

If more affordable social housing is made available, health care costs are sure to be reduced, so it makes sense to link these two matters. Governments should agree that more money should be available for affordable housing if there's an agreement to spend money on health care. I'm not sure what the actual ratio should be, but I'd venture this idea: for every extra four dollars spent on health, we should be spending one more dollar on affordable housing, at least for the next ten years.

This would mean that if an extra \$4 billion is spent on health care each year, then \$1 billion should be spent on affordable housing. If \$8 billion extra is agreed to be the amount spent on health each year, then \$2 billion should be spent annually on affordable housing (The 1 Per Cent Solution!). What's amazing about this kind of formula is that spending money on housing will actually dampen the demand for health expenditures from those who are better housed, so the bang for the extra health dollars will be big.

One of my colleagues has suggested how this can be put in government language, and that's by saying that expenditures for health and housing have to come from the same 'envelope', so that what happens in one sphere of the envelope affects another sphere.

This is an issue I'm hoping to take up during the next few months and I hope others will embrace it as well. Health care can't be talked about in a vacuum, and there's no better context to put it in than affordable housing. Maybe our attention to health care will lead to a way out of homelessness. After

(continued on page 19)

"WHY SHOULD I TRUST YOU?"

Gordon Guyatt

That was the question I heard most frequently as I went door-to-door as a candidate in the recent federal election. People expressed the question in a variety of ways, but the underlying message was clear, and providing an answer was not easy.

The public's disappointment with politicians is profound, and almost universal. As a candidate involved in doorstep discussions, I was seeking a quick way to engage voters in the minute or two of discussion available to explain my party's platform. "Canadians are fed up with broken promises," proved to be a statement that elicited nods, or exclamations of agreement, from almost everyone.

Even more disturbing, many potential voters have passed beyond disappointment, and become deeply cynical. For these individuals, all politicians are the same. Since you can't rely on any of them to keep their word, engaging in the political process is pointless. Gradually but persistently falling voter turnouts reflect the growing number of Canadians joining the ranks of the terminally cynical.

This ever-increasing alienation profoundly threatens the very core of Canadian society, democracy. Who determines the directions our country takes? Those with power, and those with leadership positions, in both the private and public sector. Large corporations, often with multinational interests, and the senior executives who run these corporations, constitute one extremely powerful force in shaping Canadian society.

Big business leaders have a legitimate primary interest in their companies' growth and profits. While many business leaders are community-minded, it is unreasonable to expect them to look after the interests of ordinary Canadians. Ensuring equitable access to high quality health care, education, childcare, and affordable housing is

simply not their job. Nor is protecting the environment for future generations. For most of us, however, the quality of public health care, education and the environment is vital to our well-being.

In tough times, access to income supports, social programs, and affordable housing is even more crucial. If citizens cannot look to government to protect what they value, to whom can they look? If they feel disenfranchised at election time, how can they act to look after their common interests?

Alienation from the political process leaves Canadians helpless, and their deep anger at this helplessness is understandable - indeed, it is inevitable.

Are politicians the dishonest, unreliable, unscrupulous individuals that so many members of the public are seeing? Overwhelmingly, I think not.

Indeed, one finds evidence of frank dishonesty and violation of trust far more often in the business community than in politicians or government bureaucracies. One need only look to Enron and Nortel, and a host of other scandals, to realize how widespread unsavory practices are within big business. In the area that I, as a health policy analyst, know best, the magnitude of fraud among for-profit companies is staggering. Columbia/HCA, the largest investor-owned for-profit hospital firm in the United States, has paid the US government US \$1.7 billion in settlements for overbilling of Medicare. Tenet, the second largest US for-profit hospital firm, paid more half a billion dollars to settle charges of giving kickbacks for referrals and inappropriately detaining psychiatric patients. These are but the largest of dozens of such settlements, and even they represent only those firms that were caught.

Nevertheless, bemoaning the disproportionate attention the media gives to the occasional serious misconduct among politicians and bureaucrats does

little good. As public representatives, Canadians expect politicians to achieve a far higher standard than the business community. The only solution to public cynicism is delivering that higher standard.

Fulfilling that objective will not be easy. It will mean resisting a host of temptations. As a candidate, I saw how much easier it is to get attention for attacks on opponents than for one's own positive policies. Yet, a "throw the blackguards out" strategy merely feeds public cynicism.

I saw how difficult it is to acknowledge all the problems that, because of financial or political obstacles, one will not be able to solve. Yet, yielding to the temptation to make promises one cannot keep has been disastrous in undermining the credibility of our political process.

I haven't been elected, but it isn't difficult for me to imagine the temptations to reward friends and supporters, a practice that in most areas of life is simply decent behavior. Yet, when dealing with public resources, such recognition represents a betrayal of trust.

When Paul Martin was elected, he acknowledged that his government must do much better. If Canadian politicians are to regain the public trust, all parties and political leaders must respond Martin's call for better performance and higher standards. ♦

First published August 21, 2004 with the Hamilton Spectator headline, "Voters demand trust: Higher ethical standards needed to overcome alienation of citizen that threatens our democracy."

CATHY CROWE PROGRESS REPORT (continued)

all, that's the history of public health initiatives in Canada, and it's what has helped drive me as a nurse to focus so much on the public health tragedy known as homelessness.

Thinking about health and affordable housing in the same envelope of expenditure is the opportunity that's before us right now. I hope we seize it. If we address the homeless questions

directly by providing truly affordable housing for the homeless then the substantial health dollars we now spend on the homeless would decline considerably.

If you would like to subscribe to Cathy's newsletter, please send a message to crowenews@sherbourne.on.ca. For more information on her work, please visit her web page at www.tdrc.net/cathycrowe.htm

There is no charge for her newsletter and she encourages you to forward it to your friends and others who you think may be interested in it and share any feedback and ideas with her at ccrowe@sherbourne.on.ca or at the Sherbourne Health Centre, 365 Bloor Street East, Suite 301, Toronto, ON, M4W 3L4♦

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