MEDICAL REFORM

Newsletter of the Medical Reform Group

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WHAT CAN WE LEARN FROM THE PRIMARY CARE REFORM PROCESS IN LATIN AMERICA?

An interview with Yves Talbot conducted by Janet Maher

Primary care is undergoing exciting transformation and it is happening all over the world. We can learn from each other. This has been my experience in working on capacity building in primary care in Latin America--YvesTalbot.

JM--Can you tell me a little of your early life? How and where you got your education?

YT--I graduated from medical school at Sherbrooke in 1971 and went to McGill to do Pediatrics. In 1975, I left for the University of Pennsylvania on a Robert Wood Johnson scholarship to do health administration, pediatrics and family care. There I studied family therapy with Sal Minuchin, then returned to the Kellogg Centre for Advanced Studies in Primary Care at McGill under the then leadership of Walter Spitzer, where my job was to look after the family and management stream of the program.

During the same period, Michael Klein who had already made the switch from pediatrics to family medicine, offered me the opportunity to try it by looking after his practice while he was on sabbatical leave , and I was hooked. The person responsible for management of fellows of the Kellogg Centre asked me to prepare some simulation of selection committees.

At the same time, Wilf Palmer, the new chair of Family Medicine at the University of Toronto had suggested my name for interview for the position of chief at Mt Sinai hospital. I had no intention of moving to Toronto but it look ed like a great opportunity to develop the role play for the selection committee. I found the best way to get a job is not wanting it. It turned out that the Kellogg Foundation was cutting back on its Canadian commitments, and so when Mt. Sinai made me an offer to do research in Family Medicine in 1982, I picked up and moved to Toronto.

JM--Can you talk a little about your recent history in Toronto?

INSIDE

YT--Well, I've been here now over 20 years, the whole time in the Department of Family and Community Medicine. I've had an opportunity to work with some of the most dedicated practitioners and teachers, and after my tenure as chief at Mt. Sinai, to be involved in the development of research in Family Medicine.

I've also had the opportunity to be involved with the PECCCAR task force on Primary Care in 1996, and since then with the international program supporting the development of primary care in countries that did not have it. Since 2001, in addition to the rest of my work, I have been the Director of International Programs for the Department.

JM--How did you get involved in Latin America?

YT--Like many of us, it began fortuitously through some visits and relationships with international colleagues. With my colleague and Chair Walter Rosser we began with the Brazilian government in 1995, as they were starting to organize primary care on a territorial basis.

That was where we designed a curriculum of five basic modules for training family physicians—initially a program for transformed the development of multidisciplinary team right from the start.

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MedicalReform

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Articles and letters on health-related issues are welcomed. Submissions should be typed, or sent by e-mail to <medicalreform@sympatico.ca>.

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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: Brad MacIntosh, 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.

WHAT CAN WE LEARN FROM THE PRIMARY CARE REFORM PROCESS IN LATIN AMERICA? (continued)

Two of the modules deal with strategies for training the people who come to our workshops to multiply the training in a quality way. The other three were based initially on the 4 principles of Family medicine, with a focus on a person's family and a community-centred rather than patient-centred model of primary care; working in teams and team relations, among professionals, a professional practice that uses the best evidence available and uses a defined territory approach to prevention health promotion with a team being a resources to their population.

JM--What has been your work there?

YT--Our biggest contribution has been in human resource development—delivering training to family physicians who will be part of primary care teams—initially in Brazil, Colombia and Chile, now moving on to Uruguay, Bolivia and most likely China, where they are working on a similar transformation.

We've found a niche using U of T resources on evidence based practice and research which address some of their weakness, and learning from their strategies for integrating the multiple disciplines and working with communities.

As I said, we have a set of 5 modules–2 of them on teaching and 3 on the principles of family medicine, which have changed some over the years, but are all focused at building teams who can work well in the local settings.

For the certificate we offer, they need to complete those modules and 3 projects

1. a team guideline on clinical practice around a common clinical problem
2. a team guideline on health promotion and prevention
3. a presentation of a clinical situation demonstrating collaboration with family and community as well as other team members.

By this time, we have provided over 4,000 certificates since 1995 in 3 countries (Brazil, Colombia, Chile). As follow-up, we now host groups of 12-15 Chileans for 6 weeks every year since 1999 (the trainees also go to Spain, Cuba, Mexico and the Southern US) to observe health systems in situ before returning to Chile.

JM--What lessons do you think you can draw for primary care reform in Ontario/Canada?

YT--Well, I think first class care is only possible where public funding is a major lever. Moreover, on e of our really central findings has been the focus on a clearly defined territory and a multi-disciplinary team approach to Primary Care.

In Canada, we have a couple of major problems. Care is focused on the individual, and the second problem is the issue of choice which complicates the principle of a territory for physicians. What results is a version of physician practice which is office-centred.

I agree with Brian Hutchinson's Big Bang paper [Hutchison et al., Primary Care In Canada: So Much Innovation, So Little Change, Health Affairs, Vol. 20, No., 3, May-June 2001, 116-31] where the strategy of getting a deal first with physicians has shaped how all the rest of the system can be organized.

Here we have public funding as in the countries of Latin America, but virtually all the services are privately organized or offered.

The other thing we need to sort out in Canada is to get away from the

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WHAT CAN WE LEARN FROM THE PRIMARY CARE REFORM PROCESS IN LATIN AMERICA? (continued)

culture of individual choice and or to use it if necessary to implement reform. It might be easiest to start with people who are starved for services, though not necessarily with a CHC model which has marginalized itself by concentrating on services to the marginalized.

There is no doubt that we are more equity oriented in Canada than the US, and that there is much room for deal-making than in a republican system, and we need to be mindful of living next door to the elephant.

Perhaps there is some value to looking more carefully at the experience of Spain which made the move in 1985 and now would not go back That move has been mainly to a territorially-oriented primary care system with coverage of one hundred per cent of their population.

Such change requires courage—the same courage we experienced in the 1960s to bring about Medicare and to deal with extra billing. Now Portugal has moved in the same direction. Naturally the UK is still the leader in primary care and its recent reform (see Michael Rachlis' last book) has followed some of the element s of the US Veterans' Administration reform.

JM--Any other observations?

YT--The other major issue in Canada is that we don't have good integration with Public Health, which is a very important element of Latin America. There is enormous potential for surveillance as well as dissemination of information to mention only a few items.

Primary care in Canada faces two challenges: interdisciplinarity as well as the interface with the professional community. The Experience of the PACT program in Ontario, a program involving communities, public health, family physicians, and pharmacists to name a few, has demonstrated the capacity to reduce antibiotic use for upper respiratory tract infection by 12 per cent while the rest of the province increased by 12 per cent, a difference of 24 per cent.

Drugs cost more and will continue to cost more that physician services. One can only imagine the possibilities for Diabetes management and prevention, Hypertension, Cancer detection, and Health promotion.♦

GETTING BEYOND THE SPIN: FEDERAL BUDGET 2005 AND WHAT IT MEANS FOR ADDRESSING THE GROWING GAP BETWEEN RICH AND POOR

Janet Maher

If we follow the government spin on the budget delivered on Feb ruary 23, 2005 by Finance Minister Ralph Goodale everything is deceptively simple and 'balanced', but Canadians are right to be wary of what difference it will actually make in their lives.

At least as important, given the proportion of federal taxes transferred to the provinces, and the revenues raised by them on their own behalf, are the uses to which those taxes are put. As even the very brief analysis here shows, a lot of money changes hands every year, and we should expect and demand better stewardship, whether we are talking about access to health services, public education or national cultural institutions, our commitments to first nations or further afield (as for example meeting the foreign aid commitment of 0.7 per cent of GNP first proposed by Prime Minister Trudeau at the United Nations in 1970, and so far not met by Canada).

Moreover, as we move on to the season of provincial budgets in April and May, we should be prepared to seek accountability from our provincial governments for transfers in the form of programs and services to address a decade or more of belt-tightening, especially for the most vulnerable.

Key initiatives in the federal budget

Subtitled 'Delivering on Commitments", the 2005 highlights document summarizes the key initiatives of this year's budget as:

- Implementation of the Government's commitment to provide Canada's communities with a share of federal gas excise tax revenues.
- $5 billion over five years to the development of a new Early Learning and Child Care initiative—a key commitment in last year's Speech from the Throne.

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GETTING BEYOND THE SPIN: FEDERAL BUDGET 2005 AND WHAT IT MEANS FOR ADDRESSING THE GROWING GAP BETWEEN RICH AND POOR (continued)

- $5 billion over five years to help fund new strategies to address climate change and protect Canada's natural environment.
- Increasing Guaranteed Income Supplement Benefits for low-income seniors by $2.7 billion over five years.
- $12.8 billion over five years (on a cash basis) to support expansion of the Canadian Armed Forces and purchase new equipment.
- $735 million over five years to address the urgent needs of First Nations communities.
- Enhancing tax assistance for persons with disabilities and caregivers through expanded eligibility for the disability tax credit and other measures.
- Raising the amount of income that all Canadians can earn tax-free to $10,000 by 2009.
- Eliminating the corporate surtax in 2008 and reducing the corporate income tax rate by 2 percentage points by 2010 to maintain Canada's tax rate advantage over the U.S.
- Eliminating the 30-per-cent foreign property limit on pension and registered retirement savings plan investments.
- $3.4 billion over five years to boost Canada's international assistance, with the goal of doubling assistance from its 2001–02 level by 2010–11.

Goodale takes pride in 'managing' expenditures, cancelling redundant programs, reducing the debt and delivering on tax cuts all at once. As a brief survey of some of these key items reveals, however, the reality is a shift toward smaller government and limitations on the commitment to programs and services which will narrow rather than increase differentials among wealthiest and the least well off.

What do some of the key initiatives mean for Canadians?

Money for communities

A staged implementation of the gas excise tax of 1.5 cents per litre will provide for the allocation of approximately $600 million in 2005-06, rising to $2 billion in 2009-10 for upgrading municipal infrastructure (roads and transit, water, sewage and garbage) which has been starved for a decade.

This year, that would mean about $20 per Canadian resident. In the City of Toronto budget debate this spring, a main bone of contention was some $100 million for 'necessary' improvements in municipal infrastructure; it's still not clear what proportion of this funding will be available to help Toronto, but it was not possible for Toronto to balance its budget without a 5 per cent increase in residential property tax and a 10 per cent increase in municipal transit fares.

Early Learning and Child Care:

This initiative is also staged and is scheduled to provide some $700 million in 2005-06 through the mechanism of a trust fund, whose terms are yet to be determined. There is reason to assume will be similar to the special funds like the Millennium Scholarship Fund devised by the Chretien government, and which for the most part depended on the agreement of provinces to get some resources directly in that case to needy post-secondary students rather than more generally for the support of post-secondary education.

Many critics in the child care sector are very concerned that funds will be transferred to provinces with no more accountability than over the decade, which resulted in no increase in formal child care in Ontario.

Addressing climate change

As in other spending areas, there are many laudable initiatives to reduce greenhouse gas emissions, retrofit Canadian homes, and support incentives for renewable sources of energy. While it's not unreasonable to imagine this as a shared responsibility, between public and private sector and among the various levels of government, the federal commitments only roll out in a substantial way by the end of the decade, when one expects the fight will need to be begun again for the following period.

Assistance for low income seniors

In 2006, this will provide an additional $18 a year, rising to $72 a year for each eligible senior by 2009-10; this assistance targets predominantly older women who rely on Old Age Security and the Guaranteed Income Supplement with limited or no access to employment-based pensions.

Supports for First Nations communities

With this promise, a little over $1billion will have been committed to the recommendations of the Royal Commission on Aboriginal Peoples released in 1996, and seems to have been consigned to lip service in most of the intervening budgets.

Aid for persons with disabilities and their caregivers

While this measure recognizes at least in principle the burden of care and support for persons with disabilities, the form of tax measures favours those with income to tax rather than the poorest, and it does little to address the increasing costs of aids and services for children and others with disabilities, to say nothing of support-

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GETTING BEYOND THE SPIN: FEDERAL BUDGET 2005 AND WHAT IT MEANS FOR ADDRESSING THE GROWING GAP BETWEEN RICH AND POOR (continued)

ing their inclusion in schools and other community programs.

Increase in Personal Tax Exemptions and RRSP limits

Like many of the other measures, this is staged, and like many of the direct tax measures of this budget, it will be of greatest benefit to middle and upper income earners who have income and therefore tax to be reduced. In effect, this kind of tax measure becomes a subsidy for those with income to invest.

The amendment to RRSP investments is a companion to earlier federal budget measures which increased limits for tax sheltering of retirement investment income, which will only be of use to those with over $100,000 income.

Along with plans to eliminate higher income surtaxes and further reduce corporate income tax, it is easy to understand the disappointment of the National Anti-Poverty Organization that their very thoughtful proposal for increasing tax equity through an increase in the child benefit and its protection from clawback by provincial governments did not even merit a mention.

Increased foreign aid

By 2010-11, the increase of about $3.5 billion will double our commitment, but still leave Canada only a little over half way to the objective of 0.7 per cent of Gross Domestic Product, proposed in 1970 by then Prime Minister Trudeau at the United Nations.

Federal Government Commitments to Health Care of Canadians

Among the biggest ticket items in this year's federal budget is the allocation of nearly $42 billion over 10 years to meet the health care related commitments of the September 2004 first ministers' meeting. In 2005-06 this 'deal' moves the federal Canada Health Transfer from $19 billion to $21.5 billion, to be allocated as part of the federal government's share of health care costs incurred by provinces and territories; thereafter the CHT will increase by 6 per cent a year, so that by 2015 the federal contribution reaches $41.6 billion.

Beyond that, the 2005 budget allocates an addition $625 million in this fiscal year to tackle wait times, and a further $805 million over the next five years to address issues as disparate as supports for internationally trained medical graduates, improvements in drug and health device safety, health promotion and public health.

What is not included?

Address the growing gap between poor and middle income Canadians

Although earlier budgets proposed new investments for supports for children and persons with disabilities would soon be rolled out, with the prospect of improvements in programs and services, this budget limits itself to tax measures, which, as noted favour middle and upper income Canadians—those with income to spend on services in any case—and will increase, not decrease the poverty gap.

Supports for young families

Early learning and parent resource centres provide some very excellent resources for parents of young children, but according to the Canadian Child Care Advocacy Association, working parents of nearly 3 million Canadian children have inadequate or insecure arrangements for their children, a situation which stresses both parents and children.

New Money for Social Housing

In the 2004 election, the Liberal Party proposed $1.5 billion in new money for social housing for the first time in over a decade. In the Throne Speech last fall, there was lip service to the crisis in homelessness. But aside from a limited commitment on-reserve housing for First Nations, and on-going consultations on housing strategy, advocates for homeless and underhoused were left in the cold again.

Some issues to ponder

As economist Armine Yalnizyan points out, total Canadian domestic product is around $1,250 billion or about $35,000 for every man, woman and child in the country. Government revenue in 2005, predominantly from income tax, is expected to be almost $200 billion or about $6,500 per person.

This is the amount available todo all the work of government, to pay off debts and take care of debt servicing, to provide transfers to provinces and territories, to pay pensions and other allowances to individuals, and support direct and purchased programs from health and environmental protection and promotion, funding of research councils, foreign aid and investments in other items considered worthy by Canadians and the politicians of the day. [1]

For most of the period since the end of the second world war, the proportion of GDP devoted to government spending has averaged 15 per cent, even taking into account the last decade of very aggressive deficit reduction, when government spending has been comparatively much leaner--closer to 12 per cent in most years since 1997.

Moreover, Yalnizyan's analaysis of Ontario revenues for its last (2004)

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FEDERAL BUDGET SPIN (continued)

budget cycle suggests we need to be alert to how the federal transfers to the provinces for health are actually recorded. She tracks the Ontario share of transfers at almost $3 billion, and projected revenue from the Ontario health premium reintroduced in 2004 at $1.6 billion, for a total of $4.6 billion new spending available for health. However, the Health and Long Term Care budget accounts for only $3.3 billion in new spending and so far none of the appropriate ministers has offered an explanation for the discrepancy.

As we approach the season of 2005 provincial budgets over the next month or so, it will be worth keeping an eye on how the increased federal transfers are reported and allocated. The only thing more galling than being led to believe we have to ration health care because spending is out of control is to find, as Yalnizyan demonstrates, that it's not really the case.

The much vaunted crisis is not in either revenue or even really in spending, but in accountability--and with a minority government in Ottawa and a fixed election date of October 4, 2007in Ontario, it behooves us to get clear answers on where the money is going before we head again to the ballot box.♦

(Footnotes)

[1] See Assessing the Federal Budget 2005: What's in it for Women? Prepared for the Feminist Alliance for International Action, March 4, 2005 and Squandering Canada's Surplus: Opting for Debt reduction and 'scarcity by design,' Canadian Centre for Policy Alternatives, April 2004.

BLOCK FEES AND BILL 8

Following a brief meeting Febraury 11, 2005, with Ministerial aide Abul Malik, Gordon Guyatt summarized Medical Reform Group recommendations in the following letter. The March 18th response from Assistant Deputy Minister for Integrated Policy and Planning Alison Pilla follows

February 14, 2005.
The Honourable George Smitherman
Minister of Health and Long Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Mr. Smitherman:

We are writing on behalf of the Medical Reform Group of Ontario to express our concern regarding block fees being charged by Ontario doctors to patients for uninsured services. We are particularly concerned about ongoing negotiations between your Ministry and the College of Physicians and Surgeons of Ontario (CPSO) regarding implementation of regulations regarding block fees based on Bill 8, the Commitment to the Future of Medicare Act. We appreciate your desire to maintain consistency with existing CPSO policies. Effectiveness in achieving your goals of protecting patients must, however, have equal or greater priority.

We applaud your Ministry in its intent to ensure that patients do not feel coerced to pay block fees, and that block fees do not in any way compromise access to insured services. We are concerned, however, that current plans will not achieve these goals.

Our concerns focus on two issues. First, the CPSO policies do not effectively address all the potential abuses associated with block fees. Physicians practicing "boutique medicine" — those charging patients large amounts to be part of practices offering specialized services that are putatively not insured — commit the particularly egregious abuses. Ambiguity in the definition of insured services may permit continuation of these abuses.

Physicians have charged block fees for increased availability to patients. The seventh point in the CPSO policy "A fee for the service of 'being available to render a service' cannot be charged in advance and is not to be included in a block fee" presumably addresses this issue. Parallel points are needed to address a number of similar issues.

Physicians have charged block fees for services that should appropriately be considered part of delivering insured services, but could be construed otherwise. A psychiatrist has, for instance, included reviewing patients' daily logs as part of the services covered by a block fee. The policy must include a provision to the effect that "A fee for services that may appropriately be considered a component of an insured service cannot be charged in advance and is not to be included in a block fee." This provision would also cover administrative aspects of delivering an insured service, such as booking operating room times.

Physicians have charged block fees for services that are not themselves insured, but are part of the necessary organizational structure of a medical practice. For instance, patients have been told that if they do not pay a block fee, their telephone calls will remain unanswered. The policy must therefore include a provision to the effect that "A fee for services that are part of the necessary organizational structure of a medical practice cannot be charged in advance and is not to be included in a block fee."

BLOCK FEES AND BILL 8 (continued)

Physicians have included their advocacy role on behalf of patients as serviced included in block fees. These advocacy activities would include, for instance, contacting other physicians to ensure their patients receive tests in a timely fashion. The policy must therefore include a provision to the effect that "A fee for services associated with the physicians advocacy function on behalf of patients cannot be charged in advance and is not to be included in a block fee."

To ensure that there is no ambiguity about these regulations we would suggest either including examples of violations in the regulations themselves, or having an attached explanatory note with clarifying examples.

The second issue of concern is the monitoring of violation of regulations. Even if the regulations are adequately formulated, it is certain that you will not stop violations if you depend on formal complaints from patients or their calling a "hot line" to report possible violations. Particularly in the current Ontario context in which many patients have great difficulty finding a primary care physician, and are thus feeling particularly vulnerable, stopping violations will require an adequate monitoring process.

We suggest that physicians charging patients block fees be required to inform the Ministry of Health and Long-term Care that they are doing so. Further, they should notify the Ministry of the individual patients to whom they are charging fees, and provide a copy of the agreement that patients sign when they agree to a block fee. Subsequently, the Ministry can conduct spot checks to ensure that this reporting is complete. We further suggest that a fee charged to doctors charging block fees support the administrative costs of this monitoring.

We look forward to your considering these issues, and ensuring that the process of dealing with block fees that emerges from Bill 8 truly addresses the problem.♦

Ministry of Health and Long Term Care
Integrated Policy and Planning,
8th Floor
Hepburn Block
Toronto, Ontario
M7A 1R3

March 18, 2005.

Dr. Gordon Guyatt
Medical Reform Group
Box 40074
Toronto, Ontario M6B 4K4

Dear Dr. Guyatt:

Thank you for your letter of February 24, 2005 to Hon. George Smitherman, Minister of Health and Long Term Care, regarding block fees. TheMinister has asked me to respond on his behalf.

The *Commitment to the Future of Medicare Act, 2004,* gives the Lieutenant Governor in Council (LGIC) the authroity to make regulations governing block or annual fees. The LGIC is not required to make such a regulation.

As you are aware, the College of Physicians and Surgeons of Ontario (CPSO) has reviewed the policy on block fees. The CPSO has recently provided the new policy to the Ministry and we are in the process of reviewing it to determine whether there are aspects of block fees that would be appropriately dealt with through regulation.

Indivdidual violations of the CPSO's block fees policy should be reported to the CPSO for investigation and any action.

The Ministry recognizes the importance of improving transparency around block fees and when they can be charged, particularly so that Ontario pateints understand the difference between an insured and uninsured service and when charges for certain health services are permitted.

I have noted your suggestions, for consideration should the LGIC make a regualtion regarding block fees.

Thank you again for your letter.♦

CANADA HEALTH COUNCIL REPORT: GOVERNMENTS, PLEASE LISTEN, AND RESPOND

The Canada Health Council's first report, released yesterday, sends a warning to Canadians that unless we accelerate the pace of change in our health care system, we are in deep trouble. The Medical Reform Group, an organization of physicians devoted to maintaining a high quality publicly funded, universal health care system, believes the Council's message is accurate and compelling.

"The report is full of accurate assessments, and excellent advice," said MRG spokesperson Dr. Gordon Guyatt. "Governments made grand statements in the First Ministers' Ten Year Plan in 2004 but, as usual, follow through has been sluggish."

In some areas, Council warnings are dire. Family physicians trained today are less interested in working the long hours of their predecessors. Fewer physicians are interested in entering family practice, and those working in family practice report high levels of burn-out. Unless governments move quickly with health care reform that utilizes integrated teams of care and modern health technology, and reform physician payment structures to make primary care more attractive, our shortage of primary care providers will get worse, not better.

"The Council's message highlights the wisdom of the Ontario government's efforts to kick-start change in primary care through their agreement with Ontario's physicians," said another MRG spokesperson, Dr. Ahmed Bayoumi. "The professions' resistance to change is distressing. The Council report should be a red alert to doctors: wake up and start co-operating with government efforts to reform primary care."

The Council report cites a whole series of other areas where slow progress endangers goals of equitable, efficient, care. Implementation of a national home care program that goes beyond immediate post-acute care is necessary if we are to decrease our reliance on more expensive hospital care. We have to train more health care professionals, including nurses, and create secure, healthy environments where they can work. We must ensure we use the money we spend on pharmaceuticals to deliver the best drugs at the lowest prices to every Canadian who needs them.

"Whether the message is training more health providers, reforming primary care, establishing national standards for extended home care, or getting tough with pharmaceutical reimbursement and practice, the Health Councils' report is accurate, compelling, and urgent," concluded Dr. Guyatt. "The MRG's message to governments and doctors is: please listen!" ♦

Released by the Medical Reform Group January 28, 2005

ONTARIO LIBERALS SHORTCHANGING HEALTH CARE

The Medical Reform Group today condemned Dalton McGuinty's Ontario Liberal government for its failure to spend dedicated health care dollars where they belong.

"The Ontario government is following in the footsteps of its Conservative predecessors in betraying the people of Ontario," said MRG spokesperson Dr. Gordon Guyatt. "The premiers promised to spend the federal health transfers on health. McGuinty promised to spend the health care premium on health. It isn't happening."

The MRG is responding to an analysis released earlier this week by health economist Armine Yalnizyan. The province of Ontario received increases in federal funding for health of almost $3 billion for the 2004-5 budget. They collected over $1.5 billion in new taxes from their health premium. But they are spending only an additional $3.3 billion on health care, a shortfall of $1.6 billion.

"In the face of an additional $1.6 billion in unspent, dedicated health care dollars, Health Minister George Smitherman's decision to choke hospitals and lay off nurses is outrageous," said Guyatt.

Yalnizyan's calculations suggest that over the next four years the Liberal plans will result in a total shortfall of $9.5 billion dollars between dedicated health income and what the Liberals plan to spend.

Where is that money going? Effectively, the Liberals are using it to balance their budget.

"Given their unwillingness to reverse some of the Harris/Eves tax cuts, this means the Liberals are behaving exactly as the Conservatives did," Dr. Guyatt continued. "They are using health care dollars to fund tax cuts. And the result will be unnecessary grief for health care in Ontario."

McGuinty's behaviour should also give the federal government a strong message that they need to tie health care dollars to specific provincial expenditures, as Roy Romanow's report suggested.

"Health care dollars should go toward ensuring an adequate supply of nurses, modernizing our health care system through information technology, and jump-starting primary care reform," Guyatt concluded. "Governments shouldn't be claiming a commitment to health care when they don't mean it." ♦

Released by the Medical Reform Group February 18, 2005

FOR-PROFIT NURSING HOMES SHORT-CHANGE PATIENTS

The Medical Reform Group of Ontario is drawing attention to an article published today in the Canadian Medical Association Journal. This important research study documents decreased staffing levels in for-profit nursing homes in British Columbia in comparison to not-for-profit nursing homes.

"This research demonstrates how for-profit facilities allocate public dollars to shareholder profits instead of patient care," said MRG spokesperson Dr. PJ Devereaux. "When public dollars go to for-profit facilities, Canadians pay more, and receive less."

The study published today in the CMAJ documented 0.34 fewer hours per-resident day of direct staff care, and 0.23 fewer hours per-resident day of support staffs care in for-profit versus not-for-profit nursing homes.

"Previous research has demonstrated that the level of staffing is associated with quality of care," said another MRG spokesperson, Dr. Gordon Guyatt. "That, of course, is no surprise. The differences in staffing documented in the current research are certainly enough to lead to important deficits in patient care in British Columbia for-profit nursing homes."

The results are completely consistent with prior research documenting higher death rates in for-profit versus not-for-profit hospitals, and higher death rates in for-profit versus not-for-profit dialysis facilities.

"It's hard to miss the pattern," said Dr. Devereaux. "For-profit health care facilities, whether they be hospitals, dialysis facilities, or nursing homes, must allocate approximately 10 to 15 per cent of their income to shareholder profits.

That means less money for patient care. As a result, for-profit facilities must cut corners, and they typically do so in the most expensive aspect of health care, provider salaries. In hospitals that means less skilled personnel, in nursing homes it means less direct care for patients."

"The bottom line is not in doubt," concluded Dr. Devereaux, "for-profit health care, including for-profit nursing homes, is a bad deal for the Canadian public."♦

Released by the Medical Reform Group March 1, 2005

NARROW SELF-INTEREST DRIVING DOCTORS TO QUESTION OMA DEAL

The Medical Reform Group be lieves that physicians like the Specialist Coalition of Ontario who are campaigning for rejection of the tentative deal between the Ontario government and the Ontario Medical Association represent a threat to health care.

"The specialists are the best-paid members of Ontario's best-paid profession," said MRG spokesperson Dr. PJ Devereaux. "In resisting the deal, they are following the model of the NHL players and owners.

That attitude of narrow self-interest may be acceptable in professional sports, but it's a problem in a caring profession. In fact, doctors could learn a lesson from what is happening with public support for the NHL players."

Doctors are an extremely powerful group. As usual, even the first deal that the doctors rejected gave them more in the way of increases than other health care workers are likely to get in upcoming negotiations with the government. And the second deal is even sweeter.

"Typically, the public supports the doctors in their tussles with the government," said another MRG spokesperson, Dr. Gordon Guyatt. "In pushing for more and more money, the doctors are betraying that public trust."

The provinces must spend the additional money from their deal with the federal government to strengthen health care. They will achieve this by updating and upgrading medical equipment, by stable funding for hospitals, and by improving home care and drug benefits. "

"The money grab by well-paid professionals threatens funding for the all the other areas in the health care system that need new investment," Dr. Guyatt reflected.

"While doctors' incomes are at the top of the ladder, there is a large income gradient between primary care doctors and specialists. The agreement begins to address that gradient. This is why it is particularly offensive for the specialists to be resisting the deal," concluded Dr. Devereaux.♦

Released by the Medical Reform Group March 22, 2005.

WHAT ARE LHINS AND WHAT WILL THEY MEAN TO TORONTO HEALTH ORGANIZATIONS

Dr. Michael Rachlis here shares a briefing note on the new Ontario health planning organizations he prepared November 29, 2004. For more information, see his website at www.michaelrachlis.com; e-mail michaelrachlis@rogers.com

What are LHINs?

- The Ontario Government announced this fall that it is proceeding with the implementation of 14 Local Health Integration Networks - LHINs. The Ministry of Health says that the LHINs will eventually take on the functions of planning, system integration and service coordination, funding allocation, and evaluation of performance through accountability agreements.
- Initially, the LHINs will assume the planning function which the Ministry claims will "help inform and shape the design and execution of the other functions".
- The government's vision for the LHINs includes establishing equitable access based on patient need, preserving patients' choices, developing measurable outcomes, sharing accountability between the provincial government, providers, user, and communities, and implementing "People-centred, community-focused care that responds to local population health needs".
- The government claims that their plan will achieve a better integrated system that will facilitate patient access, reduce wait times for five services (MRI scans, heart care, artificial joint replacements, cancer, and cataract surgery), and free up hospital beds through better access to home and long-term care.

What has the provincial government done so far?

- On September 9, the Ministry created the Health Results team led by assistant deputy minister Hugh McLeod, to lead the renewal of the Ontario health system. Team member Gail Paech is responsible for leading health system integration including the development of the LHINs. Former Toronto mayor Barbara Hall is the lead team member responsible for community relations.
- On October 6, the Ministry established the LHINs boundaries. They follow hospital referral patterns as identified by the Institute for Clinical Evaluation Sciences (ICES). There are five LHINs that cross into Toronto. The Toronto Central LHIN includes all of the old City of Toronto as well as parts of North York, East York, York, and Etobicoke. The map of the Toronto Central LHIN can be found at: http://www.health.gov.on.ca/transformation/lhin/maps/lhin_map_7.pdf. Other LHINs maps can be found at: http://www.health.gov.on.ca/transformation/lhin/lhinmap_mn.html
- The LHINs will rely on existing community boards. The Ministry will hold 14 one-day workshops over the next month to discuss the LHINs model and consult with communities and stakeholders. The Toronto Central meeting is scheduled for December 8. The deadline for registration is November 12. Registration forms are available at: http://209.167.222.48/LHINFeedback/Regen001.aspx.
- The Ministry hopes to establish LHINS' boards by April 2005 and have them provide input into the 2006-2007 budget cycle.
- The Ministry established a the LHIN Action Group to provide advice to Gail Paech on design and implementation. It is made up of approximately two dozen major provincial associations.
- The Ministry claims that its role will be to focus on system stewardship including establishing strategic directions and monitoring and reporting performance.
- Ongoing information about the LHINs development project can be found at: http://www.health.gov.on.ca/transformation/lhin/lhin_mn.html.

Is there experience elsewhere with LHINs?

- No other province currently has organizations like LHINs. But all other provinces do have regional health authorities (RHAs) which are more integrated structures than are evidently contemplated by Ontario. Quebec started their path to regionalization in the 1970s. All other provinces have regionalized since 1993, starting with Saskatchewan.
- There are examples of regional organizations in most other countries, except the United States. In the United States in the past three decades there has been growth in so-called integrated systems of care. The prototypes for these models were pre-paid groups practices (such as Kaiser Permanente) on the West Coast.
- Evaluations in the 1980s showed that these models reduced costs and increased the use of preventive services although the evidence on other outcomes was less conclusive. In the past 15 years for profit HMOs have been responsible for most of the growth in this sector. For a variety of reasons, it is dif-

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WHAT ARE LHINS AND WHAT WILL THEY MEAN TO TORONTO HEALTH ORGANIZATIONS (continued)

ficult to extrapolate from this experience to Ontario.

- The RHA models vary from province to province and details can be very important. In Saskatchewan and Alberta the RHAs subsumed the public portions of the budgets of hospitals, rehabilitation, long term care, home care, mental health, and public health. The RHAs also took over the boards and management of hospitals and publicly run services in other areas. Catholic facilities maintained their boards but became subject to regional plans.
- In general smaller provinces tend to have less than 100,000 population on average per RHA while BC and Alberta have more than 300,000 per RHA. Quebec has recently implemented a plan with 95 Local Services Networks with an average population of 76,000. In the smaller provinces and Quebec, RHAs outside of metropolitan areas typically have less than 50,000 people. The cities of Montreal and Vancouver are within one region although there are major portions of their greater metropolitan areas which lie outside their geography. No other cities have been divided into more than one health region.
- There has been little evaluation of the RHAs that would provide conclusive lessons for Ontario. However, prior to their latest reforms, Quebec did have a similar model to the one being proposed in Ontario. The main rational for the disestablishment of the boards of hospitals, public long-term care facilities, and the CLSCs (Québec's network of community health centres) was that it had been too difficult to establish integration using existing organizations.
- While it is not clear what organizations might initially be subsumed into the LHINs, there is speculation that the LHINs will initially include the 7 Ministry of Health and Long-Term Care regional offices and the 16 District Health Councils.

What does this mean for the health organizations in South East Toronto?

- At present, the only function transferred to the LHINs from the Ministry is planning. There will be no immediate changes to budgets or service. It appears that significant change will be postponed at least 1 ½ years until the implementation of the 2006 provincial budget. The ministry will have to overcome political opposition to have the LHINs assume the other contemplated functions.
- The boundary changes with LHINs mean that there will be much less focus on the city and its institutions. The Toronto Public Health Department will remain, for now, as a municipally based organization but it will have to deal with 5 separate LHINs. The Department will find it a major challenge to effectively participate in five separate planning processes. In the future, there may be pressure to transfer public health departments to the LHINs.
- In the short term, Toronto Central is less affected than other Toronto-area LHINs because it is all within the city of Toronto.
- Communities are strengthened when public institutions have coterminous boundaries. If services like education, public health, and social services share boundaries it makes it much easier for citizens get services, particularly if they need a lot of services. Citizens and their organizations also find it easier to participate in decision-making.
- Intersectoral action on the determinants of health is easier to develop at the municipal level rather than at provincial or federal levels. Toronto was the home twenty years ago to the international Healthy cities Movement. Although that initiative waned here, it has grown in Quebec and Europe. It could be argued that the broad intersectoral policy-making of the healthy cities movement is reflected in the Toronto City Summit.
- The LHINs are based on tertiary care referral patterns. This makes it more likely that their focus will be tertiary care matters which are also the most politically compelling. In other jurisdictions, even with a stated goal for reallocation to community services, new regions sometimes siphoned resources from community health services to institutions.
- Public health and prevention services are vulnerable because a focus on averting deaths in the future usually means a lack of a vocal constituency in the present. Community services are vulnerable because their true value is unappreciated and they aren't glamourous enough for TV. Mental health services are especially vulnerable because their clients usually lack resources to be effective advocates.
- Some other provinces implemented policies to ensure that resources were re-allocated to community care. In Saskatchewan they used a so-called "one-way door" where regions were allowed to move money out of institutions but not into them. It did increase reallocation but it also led to some gaming.

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WHAT ARE LHINS AND WHAT WILL THEY MEAN TO TORONTO HEALTH ORGANIZATIONS (continued)

- Other provinces have tried partly electing boards but no province currently elects board members. They are appointed by the provincial government. Turnouts in health board elections were typically very low. The boards were not captured by single-interest groups although that had been feared.
- Some health regions such as Saskatoon, Calgary, and Edmonton have used their integrated budgets to develop more integrated seamless services. For example, they have been able to keep a low census of patients awaiting placement in long-term care facilities.
- Saskatoon has had less than 1% of their acute care patients awaiting a long term care bed for four years. Gradually the regions are developing more region-wide programs such as palliative care and diabetes education. In Calgary less than 35% of cancer patients die in hospital (compared with over 70% in other parts the country) and almost all AIDS and ALS patients also die outside of hospital. Edmonton centralized intake and redesigned their diabetes education services and decreased wait times by almost 90%.
- In the short term resources will be allocated according to historical aliquots. But, the province could be pressed to provide an innovation fund which would hasten the development of projects needed to fill gaps in services.

Questions still to be answered

- What will be the operational goals for the LHINs and what will the accountability contracts look like? Will they include population health indicators e.g. % HIV rate in IDUs, % stable housing for people with serious and chronic mental illness, or will they focus on wait times for surgery?
- What functions will the LHINs acquire? Will they just stay as planning bodies and become extended DHCs? If they are given resource allocation then they might become mini-ministries of health. Finally they could evolve into RHAs which also directly run many services.
- It is politically easier in the short term to only take on the planning function but the lessons of other jurisdictions are that budgetary integration does appear necessary for system re-design. How can we prevent short term harm to patients by policies which aim to provide better care in the future?
- If LHINs acquired resource allocation, would it be any easier for them for to create winners and losers than it would be for the Ministry?
- How will the LHINs be staffed? Will they encompass the present staff in DHCs and other organizations they subsume? Will the ministry move staff to the LHINs? Labour readjustment strategies have been key to facilitating real integration. Saskatchewan has the most comprehensive legislation covering realignment of labour after regionalization.
- How will physicians in private practice relate to the LHINs? How will the LHINs initiative dovetail with reforms to physician payment including primary medical care reform and academic alternative payment plans? In Alberta the association representing RHAs now sits at the bargaining table with the provincial government when they negotiate with the Alberta Medical Association. Will the LHINs evolve to take on direct relationships with physicians?
- What will be the role of the for-profit sector? Will the LHINs be a vehicle to contract out more services, especially short-stay surgery? Will Elinor Caplan's review of CCAC contracting have any implications for the LHINs?
- What opportunities will there be for innovation, especially in the short-term? Are there successful examples of implementation we can follow?♦

MONEY WELL SPENT

Gordon Guyatt

Earlier this month, Health Minister George Smitherman announced $120 million for upgrading high-tech health imaging and radiation equipment. Is the announcement reason to celebrate, or more reason to worry about unsustainable health care spending?

Consider: if Canada produced 10,000 more SUVs that Canadians purchased and used, our gross domestic produce (GDP) would rise, and newspaper editorialists would celebrate our well-functioning Canadian economy. The same would be true if we produced and purchased an additional 10,000 television sets.

What, however, if 10,000 additional Canadians undergo hip replacements that free them from crippling pain? Despite the fact that these individuals will be more highly functional, and despite the fact that our GDP will increase, the pundits' reaction would differ. Many commentators would see this increase in production as bad news, a drain on the economy, and more reason to worry about unsustainable health spending.

The purpose of a productive economy is to meet our basic needs, and keep us as happy and satisfied as possible. The cost of fixing a badly damaged hip is intermediate between the price of a television set and an SUV. Even neglecting the environmental problems of the SUV or the negative effect of the television on our family lives, many would consider the hip replacements as contributing more to our national well being than producing more consumer goods.

Over the last 20 years every industrialized country has increased the proportion of GDP spent on health care. That's because the health sector is increasingly able to deliver services people value highly. Preventing disability in old age by hip and knee replacements, blindness by cataract replacement, curing leukemia in young children - the list of health "miracles" goes on and on.

We don't get upset when we see enormous growth in what we spend on computers, DVDs, and a whole range of technological gadgets. So, if it's delivering innovations in a product that we value extremely highly - our health - why the angst about health care spending?

One reason is our national anxiety over "unsustainable" health care spending. As it turns out, this anxiety results from the most successful hoax ever perpetrated on the Canadian people.

Although not often explicitly stated, what we worry about is that health care will crowd out other goods and services on which we'd like to spend our money. What would happen, for instance, if health care spending grew 1 per cent faster than the rest of the economy for the next 50 years?

As it turns out, at the end of 50 years, economic growth would prevent any deterioration in spending power for goods and services outside the health care arena. Canada is likely to continue with an average 2 per cent real growth in GDP we've seen in the last decade. Given this continued growth, if down the road we spend 15 per cent of our GDP on health care instead of the 10 per cent we do now, we will still have more money overall to spend on everything else.

And, if the last decade is any indication, growth in health care spending may not consistently outstrip growth in the rest of the economy. In 1992, Canada spent 10 per cent of its GDP on health care. For a few years after 1992, health care spending grew less than the rest of the economy; the last 5 years, we've been catching up, and 12 years later health care is back at 10 per cent of the GDP.

This is not an argument for profligate health care spending. We must ensure value for money. Increases in income for well-paid health professionals will not improve health care. The best evidence tells us that directing public dollars to for-profit health care will increase expenditures, and decrease quality.

We can, and should, improve the efficiency of our system by ensuring adequate home care that minimizes our dependence on hospitals. We should use drugs wisely, and pay only for expensive new products if they offer substantial additional benefits and have demonstrated safety.

But at the same time, we should abandon our false notion of health care spending as a threatening drain on the economy. Health Minister Smitherman's investment in new equipment will provide the infrastructure for optimal diagnosis and treatment for Ontario citizens with health problems - that's money well spent. When done right, growth in our health care sector delivers a product that enhances Canadians' well being more than expansion in any other part of our economy. ♦

First appeared in the Hamilton Spectator, February 26, 2005

PRESCRIPTION FOR EXCELLENCE: SOME IDEAS WHOSE TIME HAS COME

Gordon Guyatt

Michael Rachlis is a frustrated doctor. These days, that's not a rare species.

But the source of Dr. Rachlis frustration is very different from most of his colleagues, and so is his way of dealing with that frustration.

After years of practice as a family doctor, Rachlis made a career shift and, for the last 15 years, he has taken the role of one of Canada's leading health policy analysts. For much of that time, Rachlis has been prodding Canada's health care establishment to focus on innovation and quality improvement.

Almost everyone acknowledges that Canada – like every other industrialized country – has a health care system that is struggling to cope with rapid technological advances, increasing patient expectations, an enormously powerful multinational pharmaceutical industry, and constrained resources. Right-wing ideologues – note Ralph Klein's latest assault on universal, non-for-profit health care - see private pay and for-profit health care provision as the solution. Most Canadians see the system as structurally sound, but requiring more resources to fill highly publicized potholes.

Rachlis sees both sides in the debate ignoring a much wiser solution. High quality care not only leads to better health, Rachlis argues, but also is less expensive to deliver. We have numerous examples of improved quality right in front of us, in the form of innovative health care programs dotted across the country. The challenge is to take those isolated programs and weave them into a new, improved structure of health care delivery.

Like most of us, doctors generally respond to their frustrations by complaining, and getting on with their business. Over a year ago, Rachlis released a new book, "Prescription for Excellence", that challenged Canadians to put innovation and quality improvement at the center of the health care debate.

Rachlis has no doubt that public-pay, not-for-profit health care delivery serves Canadians well. He makes a valiant effort to dispel the myths perpetrated by those who would like to see us move toward American-style health care delivery.

Health spending is not out of control. In terms of its Gross Domestic Product, Canada spends no more on health than it did a decade ago. There is plenty of money for public health care, if we allocate our resources wisely. Federal government spending has dropped from over 22 per cent of GDP to under 15 per cent a 54-year low.

Rachlis main message though, is that if we only spent our money wisely, we would need few if any increases in expenditure. In a very readable style that he describes as "evidence-based story telling," Rachlis presents dozens of ways that we could improve health care quality, and possibly reduce costs.

One of Rachlis' important principles is to move as much of care as possible out of hospitals, into the home or other specialized facilities. For the dying, he advocates specialized palliative care programs, with provision of all the care needed for families to deal with terminally ill family members. He sets targets for which communities can strive. More than 50 per cent of cancer deaths should occur outside the hospital. For the elderly in nursing homes, more than 70 per cnet of deaths should occur in the home rather than the hospital.

Home care can also keep the acutely ill out of hospital. Quick response teams can initiate or intensify home care to allow people to stay at home during a significant, but not life-threatening, illness. Adequate home care availability allows early discharges from hospital. Both measures can free up emergency room beds, clogged with patients waiting for admission to hospital.

Traditional models of health care have family doctors, specialists, and other services such as social work and occupational therapy working more or less in isolation. Rachlis believes that teams of family doctors, nurses, nurse practitioners, specialists, and other health workers can delivery better care, more efficiently.

These ideas come together in the concept of chronic disease management. First, computerized systems identify all the patients in a groups' practice with conditions such as diabetes, asthma, or heart failure. Evidence-based protocols lay out the optimal management of these patients, and monitoring mechanisms ensure that the team delivers this best-practice care. Patient education and support ensures that patients themselves lead as much of the monitoring and management as possible.

Rachlis presents other innovative ideas to deliver more humane care to those in long-term care facilities, increase effective prevention practices, decrease harmful drug administration, and manage wait lists more effectively. Altogether, an ambitious agenda.

Far from being a lone voice, Rachlis has strong advocates for many of his proposals. Roy Romanow, whose report recommended expansion of palliative and home care, and primary care reform, continues to remind us that additional money won't be enough to bolster a stumbling health care system.

What is the key ingredient to bringing innovation to the front of the health care agenda? Leadership, both at the political level, and within health care administration. More than a year after "Prescription for Excellence" put the quality improvement case so compellingly, that remains the most difficult challenge to meet.♦

SEEKING ACCOUNTABILITY ON CANADA HEALTH ACT VIOLATIONS

Early in the New Year, the Medical Reform Group joined other members of the Canadian Health Coalition to remind Health Minister Dosanjh, his parliamentary secretaries, and members of the House of Commons Standing Committee on Health of our concerns around recent enforcement of the Canada Health Act in the following terms. Also, see our media release elsewhere in thi sissue on the occasion of the tabling of the Annual Report in the House of Commons. No answers had been received at press time.

Monday, January 17, 2005

I am writing on behalf of the Medical Reform Group, a voluntary association of physicians committed to the mainte nance of publicly funded health care for all Canadians.

In 2002, the Canadian Health Coalition launched an action in federal court because Parliament was denied important information on the Canada Health Act. In a federal court ruling in late 2004, Mr. Justice Mosley said: "While the application raises important questions, there are of an inherently political nature and should be addressed in a political forum rather than in the courts."

It is now up to members of Parliament to take up the important issues raised in the Federal Court. Canadians view the Parliament of Canada as an important guardian of Medicare and the values it embodies. Indeed, the Parliament of Canada has unique duties with respect to overseeing the national health care system. Under the Canada Health Act, the Minister of Health has reporting obligations to Parliament and must monitor and enforce compliance with the five criteria and two conditions of the Act.

In recent years, Auditors General have documented serious deficiencies in the Minister's monitoring of, reporting on, and enforcement of the Canada Health Act. Evidence demonstrates that the proliferation of private for-profit clinics directly charging patients to jump the queue can undermine the objectives and purpose of the Canada Health Act. In particular, two-tier access to medical services, like MRI tests, violate the Canada Health Act requirement that universal access to publicly funded services be provided on uniform terms and conditions.

The Minister's Annual Report to Parliament on the Canada Health Act consistently fails to identify or assess the extent to which for-profit clinics are levying user fees. It is public knowledge that such clinics are proliferating in British Columbia, Alberta, Nova Scotia, and Quebec. Public health care in Canada is too important for Canadians and their parliament to be kept in the dark about developments that threaten the integrity and viability of Medicare in this country. Now that there is significantly more federal funding for Medicare, Canadians expect more not less accountability for how and where our money is spent.

The next annual report to Parliament on the Canada Health Act for 2003-04 is due to be tabled shortly. We trust that you will help ensure that this report is full of accurate and up-to-date information, not full of holes.

We look forward to working with you on this urgent matter.♦

CANADIAN GLOBAL HEALTH INITIATIVE: WHERE ARE THE WOMEN?

Cathy Nangini

In the Democratic Republic of Congo (DRC), tens of thousands of women and girls have suffered crimes of sexual violence over five years of armed conflict, and despite a 2002 peace agreement, they continue to be deliberate targets. This is an urgent medical and human rights crisis that must surface above the tsunami of terrorism hysteria that dominates the world stage—and Canada is well-positioned to do it.

Aileen Carroll, Minister of International Cooperation and head of CIDA , calls for Canadian foreign aid and assistance to be more rooted in Canadian values, and there is no shortage of political cheerleading from federal officials on Canada's role in establishing an international example of good will, not to mention good business. Paul Martin and Ernesto Zedillo, Mexico's former president, co-chaired a 2004 UN report ("Unleashing Entrepreneurship") providing incentives for Canadian firms to do business in Africa, and CIDA created an entire program to help private investment under the Canada Investment Fund for Africa.

No such equivalent has been developed to address the wholesale violation of human rights against countless women in Africa, such as in the DRC. While Canada is happy to co-chair the UN report, commissioned to identify "legal, financial and structural obstacles blocking the expansion of the indigenous private sector in developing nations", nobody is asking for a roadmap outlining the obstacles to expansion of health care for women who are caught in conflicts that use violence and rape as a strategic tactic of war. As it is, CIDA's position on this issue in the DRC is noncommittal, and its plans are vague.

However, a duo of sMRG students are leading an initiative to call CIDA's attention to the DRC. They have launched a campaign to raise money for the Panzi hospital in the eastern city of Bukavu, South Kivu, where director Dr. Mukwege can perform fistula repair surgery for countless rape survivors.

The students are supported by close to a thousand who have signed postcard petitions directed at Minister Carroll urging her to recognize the overwhelming need for medical assistance in the DRC, and are planning to deliver the postcards to the Minister in a few weeks. In the meantime, they are preparing a proposal that outlines a plan for implementing medical aid through CIDA, based on the resource needs of the Panzi hospital as a starting point.

The students are seeking help from doctors with experience in gynecology/fistula repair and health care workers who deal with sexual abuse cases to advise them on their proposal. For more information on supporting the campaign, please see www.medicalreform.ca/congo.htm♦.

Cathy Nangini is a graduate student in the Department of Medical Biophysics at the University of Toronto, and a member of the MRG Student Chapter.

REPRODUCTIVE HEALTH WORKING GROUP TO MEET

Following the report of Dr. Rosana Pellizzari on her field experience in Costa Rica in our summer 2004 issue, she recommended we consider a review of MRG policy on the issue of reproductive and sexual health, especially in light of the decline of NAC and other women's organizations who had monitored political developments in Canada and abroad a little more assiduously.

While we hope that the acrimony of thereproductive choice debates of the 1970s and 1980s has passed, there are a number of situations which bear some monitoring for policy implicaions.

These include findings of many researchers in Canada and elsewhereof alarming rises in STDs. As well, the announcement by Health Canada of its intention to extend emergency contraception through pharmacists appears to have provoked some threats of resistance from some providers. Finally, the announcement in January of the plan of the Manitoba goverment to appeal a superior court decision on the funding of out-of-province abortions, reminds us of the work still to be done to ensure all Canadians have equal access to high quality sexual and reproductive health services.

To kick off the working group, Rosana Pellizzari has agreed to host an initial meeting at her Toronto home, Saturday, April 9th, 2005, from 2 to 4 pm. If you or someone you know is interested in joining the group please contact the Medical Reform Group at medicalreform@sympatico.ca; or (416) 787-5246 [voice]; (416) 352-1454 [fax] for further details.♦

CAMPING IN NATHAN PHILLIPS SQUARE

Like many other cities, Toronto is forced to deal with the failure of senior levels of government to deal with a gorwing problem of homelessness. The Medical Reform Group joined many other members and supporters of the Toronto Disaster Relief Committee in discouraging the Mayor from banning 'camping' on the main city square.

February 1, 2005.
His Worship David Miller and members of Council
Toronto City Hall
100 Queen Street, West
Toronto, Ontario
M5H 2N2

I am writing on behalf of the Medi cal Reform Group to express some of our concerns about the Mayor's strategy, From the Street into Homes, in anticipation of the February 2 council debate on the issue.

We commend initiative of the city in developing a strategy to help homeless people find permanent housing. Like many others, we believe the current shelter system is inadequate in that it fails to meet the needs of a growing number of people who cannot afford housing; moreover, basic maintenance standards belie the notion of a healthy environment. As a result, the incidence of tuberculosis in increasing and now includes staff members at some shelters. There are serious bed bug infestations leading to infections and discomfort for residents. And finally, shelters are overcrowded, causing increased stress and safety concerns.

The solution, as you are aware, is permanent, affordable housing. The allocation of $14.2 million is welcome, as is the commitment of previously promised funds (SCPI and the Mayor's Homelessness Initiative Reserve Fund). However, in your recently released strategy, we see no indication of a willingness to put new money forward. These new funds would be required to provide more than the 1,000 new affordable housing units which would be made available from the announced funding. Furthermore, subsidies to make the large number of vacant apartments affordable would be welcomed by both the homeless and landlords.

Moreover, sufficient housing would make the amendment unnecessary. When homes are made available, people are willing to leave the streets. For example, when homes were found for people living in Tent City, they were satisfied to leave their makeshift homes and to this day they remain housed. Similarly, those who were living under the Bathurst Bridge have not returned to the street. When the Edward Street Shelter was opened, it was filled immediately and the numbers of people sleeping in Nathan Phillips Square dropped dramatically.

Street nurses who care for homeless people report that it's much easier to address their care needs in an open public space. Homeless people themselves have stated that they feel safer in Nathan Phillips Square—it is well lit and safe. When people have no place to stay and the safest place is banned, you merely force them to move into more remote and dangerous locations. Removal of the homeless from the public eye therefore results in increased danger to both the homeless and their caregivers, making care delivery difficult and time-consuming; three is a further danger that some homeless individuals may not be reached at all.

There are many unanswered questions raised by this new strategy, such as: what criteria will be used to determine what other sources of shelter have been offered and declined? Who will be the decision-maker? What records will be kept? What means will be used to remove individuals from the square? Why has Nathan Phillips Square been singled out as the only place from which the homeless will be removed despite its obvious advantages?

In summary the Medical Reform Group applauds the initiative of the Mayor and Council to end street homelessness, and supports many of the strategies outlined in the report. However, the reliance on overcrowded, unhealthy shelters and the removal of people from Nathan Phillips Square is not acceptable.

In conclusion, we offer the following recommendations, and look forward to their implementation in the coming weeks and months:

1. Drop the proposed ban on 'camping' in Nathan Phillips Square;
2. Commit at least an additional $14.2 million for new subsidized housing to match the $14.2 in reallocated dollars;
3. Create a city-community committee to ensure the delivery of new homes, and include on the committee at least one street nurse or community health nurse;
4. Set the city's 2005 target at 3,000 new affordable homes;
5. Amend the street outreach strategy to ensure the replacement of temporary beds due to disappear in the when Edward Street and Out of the Cold programs are closed in the spring.♦

TIPS FOR HEALTH PROVIDERS ON COMPLETING SPECIAL DIET PRESCRIPTIONS/FORMS FOR CLIENTS ON ONTARIO WORKS (OW) OR ONTARIO DISABILITY SUPPORT PROGRAM (ODSP)

This tip sheet has been assembled by Toronto Street Health providers to assist colleagues in serving clients on assistance. Please feel free to distribute.

Your clients on OW and ODSP are eligible to receive additional money every month to enable them to purchase dietary items. Such items must be prescribed by a Physician, Registered Nurse (Extended Class), Registered Dietician or Registered Midwife (pregnancy/breastfeeding and infant diets only).

Although most health providers know that social assistance recipients are unable to afford nutritious or sufficient amounts of food over an entire month (McIntyre et al, 2003), sometimes providers are unaware of the possible dietary funds available to clients. When dietary requirements are carefully considered by a health provider, clients can receive significant additional funds each month.

Below are some factors to consider when prescribing special diets. Note that an actual "Special Diet" form must be completed for ODSP recipients, and the provider's signature must appear beside each selection. For OW recipients, there is no form. One may either write a letter on letterhead or use a prescription pad. The complete policy and diet schedule can be found at www.city.toronto.on.ca/socialservices/Policy/spdiet.htm. It is helpful to refer to the schedule while completing the form or letter.

General tips:

- More than one type of diet may be prescribed
- There is a maximum monthly allowance of $250 for dietary needs
- It is useful to make a copy for the chart as OW recipients are often asked to renew letters q 6 months
- Increasing income is one of the most important health interventions we can facilitate
- For all clients, consider "vitamin/mineral/herbal supplements," "organic diet," "bottled water"
- All women can get extra monies during pregnancy and while breastfeeding
- Monies are allowed for clients with dietary restrictions including egg free, milk/dairy free, wheat free, gluten free, reduced phosphorus, reduced protein, low fat, low cholesterol, sugar free, sodium reduced, low residue
- In clients having or at risk of osteoporosis (for example, smokers or women using progesterone-only methods of contraception) consider "high calcium" diet
- In clients with low BMI, consider "high calorie/high protein" diets
- In clients with difficulty chewing or swallowing consider "prepared supplements" (you may choose the number of servings per day)
- In clients with recurrent cystitis or at risk for same, consider "cranberry juice"
- Consider diets for conditions including cystic fibrosis, diabetes, gestational diabetes
- Consider "organic diet" especially for anyone who would benefit from pesticide/toxin free food (for example, liver condition such as hepatitis B or C, elevated LFTs or cirrhosis, renal disease, history of cancer or environmental sensitivities or anyone concerned about food borne toxins)
- In clients having or at risk for iron deficiency anemia (for example, low ferritin, menorrhagia) consider "iron rich" diet.
- Consider "prunes" and "high fibre" allowances for those with chronic constipation or who are taking chronically constipating medications such as opiates.♦

SOME WEBSITES OF INTEREST

For those who would like to follow some of the campaigns ofour allies, have a look at:
Canadian Health Coalition at www.healthcoalition.ca/
Ontario Health Coalition at www.web.net/ohc
Canadian Centre for Policy Alternativesat www.policyalternatives.ca/

For those who have an interest in the work of Dr. Philip Berger, read his dispatches from Lesotho at www.opseu.org/campaign/liveandletlive/lesothoindex.htm or the Stephen Lewis Foundation at www.stephenlewisfoundation.org♦

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

Name _____

Address _____

City _____

Prov/Postal Code _____

Telephone _____

Fax _____

E-mail _____

Membership fees:

Supporting member	Over $195
Physician	$195*
Medical Student	Free
Affiliates and all others	$ 50

Please return to:
Medical Reform Group
Box 40074
Toronto, ON M6B 4K4

Areas of Expertise _____

Areas of Interest _____

I can be called on to assist with _____

Present Position _____

Membership Category _____

Fee enclosed _____ Donation _____

Please charge my MASTERCARD/VISA in the amount of $_____. My MASTERCARD/VISA Account number is _____
Name of Accountholder _____
Expiry Date _____

All categories of membership include a subscription to the MRG newsletter **Medical Reform.**
***** Physicians in provinces other than Ontario may become Affiliate members.

If you prefer, you may pay your membership fees and supporting contributions through our monthly payment option by completing the following authorization and ***enclosing a blank cheque, marked "VOID" from your appropriate chequing account.***
I authorize my financial institution to make the following electronic payments directly from my account:
The amount of $_____ on the first day of each month, beginning _____, 20___. Please credit the payments to the METRO Credit Union account (No. 1148590) of The Medical Reform Group.
I understand that these electronic payments will continue until I give notice in writing to the Payee to stop doing so; that I must notify the Payee in writing of any changes to the information in the authorization; and that I must notify the Payee within 90 days of any error in the electronic payment.

_____ _____ _____
Account holder's name (Please Print) Account holder's signature Date

MRG SPRING MEMBERS MEETING

HOMEFREE, HOMEBOUND, HOMELESS: GETTING HOME CARE BACK ON THE PUBLIC POLICY AGENDA

WITH

CAROL KUSHNER,

HEALTH POLICY ANALYST

WEDNESDAY, MAY 11, 2005
7 TO 9 PM
MEDICAL SCIENCES BUILDING, UNIVERSITY OF TORONTO
[call or watch signs for exact location]

Admission: Students--Free
All others--$10
For more information: (416) 787-5246; medicalreform@sympatico.ca

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

Please visit and comment on our web-site
at http://www.hwcn.org/link/mrg
Please also make a note of our current telephone
(416) 787-5246; fax (416) 352-1454; e-mail: medicalreform@sympatico.ca