
Medical Reform

Newsletter of the Medical Reform Group



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CMA MOVES TOWARD PRIVATE HEALTH CARE AT ANNUAL MEETING

Irfan Dhalla

The Canadian Medical Association made several moves at its annual meeting indicating a shift among the association's leaders toward private health care and away from Medicare.

During the meeting, from August 20 to 23, delegates elected Dr. Brian Day as president-elect of the CMA. Dr. Day, an orthopedic surgeon who owns and operates a private surgical centre in Vancouver, has argued that the Canada Health Act ought to be repealed and has repeatedly compared Canada's health care system to those of North Korea and Cuba.

A last-minute challenge from the more moderate Dr. Jack Burak, a former president of the British Columbia Medical Association, failed to generate enough support to prevent Dr. Day from assuming the presidency.

The 246 delegates at the CMA meeting also strongly endorsed a motion that would allow physicians to practice in both the private and the public sector simultaneously. Many observers, including the Medical Reform Group, Canadian Doctors for Medicare, the Canadian

Health Coalition, as well as health policy experts, argue that dual practice of this nature is inconsistent with the notion that access to care should be based on need and not an ability to pay. With doctors able to practice in both sectors simultaneously, three major problems arise.

First, patients can buy their way to the front of the line, so access to care is based on wealth rather than need. Second, human resource shortages in the public sector are exacerbated. Third, because the private sector succeeds only if public care is mediocre or worse, physicians practicing in both sectors have a

disincentive to help improve public care.

Also at the meeting, the Canadian Association of Interns and Residents put forward two motions designed to clarify the CMA's position on privately funded health care. Last year, when CAIR had put forward a motion asking the CMA to reject private health insurance because of the principle that care should be need-based, the CMA split the motion, voted overwhelmingly in favour of the principle that access to care should be based on need alone, but then defeated the portion of the motion that argued for a prohibition on private insurance.

To avoid confusion, this year CAIR put forward two explicit motions that could not be divided—the first motion asked delegates to acknowledge that the introduction of private health insurance is inconsistent with the principle that access to care should be based on need and not an ability to pay, and the second motion asked delegates to reject the introduction of private insurance as a solution to excessively long wait times.

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

Editorial committee this issue: Norman Kalant, 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.

CMA MOVES TOWARD PRIVATE HEALTH CARE AT ANNUAL MEETING (continued)

Despite support for these motions by outgoing CMA president Dr. Ruth Collins-Nakai, delegates voted to defeat both CAIR motions by wide margins. Said Dr. Collins-Nakai, "Medicare has been good for patients and it's been good for doctors. If we begin to put doctors' interests ahead of patients' interests and advocate a parallel system ... we will lose public trust."

Unfortunately not enough of Dr. Collins-Nakai's colleagues agreed with her. The CMA's own synthesis of the evidence, presented in a paper entitled "It's About Access!" confirmed that private health insurance "has not been found to improve access to publicly insured services, lower costs or improve quality." The report presented 4 scenarios for the future—the status quo, and 3 options with successively more private funding. Unfortunately the CMA did not present a fifth option, the scenario recommended by the National Forum on Health, Romanow and Kirby, namely increased public funding and innovation within Medicare.

A morsel of good news from the CMA meeting was that the federal Minister of Health, Tony Clement, repeated that the Conservative government fully supports the Canada Health Act. In fact, when a delegate asked Minister Clement to recognize that the Canada Health Act was outdated, Clement refused. Instead, he pointed to the innovations that are possible—and indeed happening—within Medicare.

Opposition to the CMA's move toward privatization came from many sources, including most notably a new organization called Canadian Doctors

for Medicare. Dr. Danielle Martin, chair of Canadian Doctors for Medicare, was visible throughout the meeting, and interviewed by all the major newspapers and television stations. To join Canadian Doctors for Medicare, please visit www.canadiandoctorsformedicare.ca.

Dr. Hedy Fry also spoke in support of Medicare, and tried to allay concerns that Dr. Day will have the ability to shift CMA policy. Fry, a Liberal MP who is running for the leadership of the Liberal Party, was quoted on a Vancouver radio station as saying the results don't mean that "Canada's universal health care system is dead. At the end of the day, when he's the president, he will have to represent not Brian Day, but the Canadian Medical Association. We know that 95 per cent of doctors support Medicare."

Although Dr. Fry may be correct, Canadians would not have received that impression from observing the CMA meeting. Organizations like the Medical Reform Group and Canadian Doctors for Medicare will have to continue to work to ensure that Canadians know that many physicians do support Medicare, and to educate our colleagues about the reasons why single-tier, publicly funded healthcare is more equitable, more efficient and of higher quality. To do this, we will be looking to you for your ongoing support. ♦

BC MEDICAL ASSOCIATION LINES UP BEHIND TWO-TIER ADVOCATE - A DISCREDIT TO THE PROFESSION

The Medical Reform Group is deeply troubled by the actions of the BCMA in its support of privatization advocate and President-elect Brian Day, and its request that Dr. Jack Burak's reverse his decision to challenge Dr. Day for the Presidency.

In a multi-candidate election to select the British Columbia Medical Association's designate for CMA President, Day won more votes than any other candidate. However, less than one-third of B.C.'s doctors cast a ballot, and only one-quarter of the voters selected Dr. Day.

"The process of Dr. Day's selection leaves no credibility to the claim that his views represent those of the majority of Canadian physicians," said MRG spokesperson Dr. Gordon Guyatt. "Dr. Day is an extremist who takes a position that is anathema to most Canadians: a move toward two-tier medicine where the rich pay for quicker and better care, and ordinary Canadians move to the end of the line."

The BCMA has not only asked Dr. Burak to withdraw his challenge, but also committed resources to Dr. Day in support of his candidacy.

"Canadian doctors should be welcoming Dr. Burak's challenge," said another MRG spokesperson, Dr. Ahmed Bayoumi. "Dr. Burak's support of the fundamental principles are, in contrast to Dr. Day's, in keeping with the best interests of the Canadian public."

"The BCMA just doesn't get it," Dr. Guyatt concluded. "Having a President who takes such an anti-evidence, anti-people position will be disastrous for the medical profession. At the very least, the profession deserves an alternative choice." ♦

Released by the Medical Reform Group, Tuesday, July 18, 2006.

MESSAGE TO THE CMA: CHOOSE PUBLIC INTEREST, NOT SELF-INTEREST

Gordon Guyatt

Last month, the Canadian Medical Association presented the public with four choices regarding the future of Canadian medical care. Their options include the status quo and three progressively more extreme moves toward privatization.

Unfortunately, they left out the fifth, best choice — strengthening publicly funded health care, delivered by not-for-profit providers.

The CMA position paper reflects the ferment that followed last year's Supreme Court ruling in the Chaoulli case. That 4-3 decision potentially opened the door to private insurance for health services.

Since the stinging defeat of the 1986 province-wide doctors' strike

that followed Ontario's ban on extra-billing, doctors' organizations have been relatively quiet regarding the fundamental tenets of medicare.

That changed with Chaoulli. While limited in legal scope, the decision has emboldened advocates of private-pay and for-profit medical care delivery. At the CMA's national meeting in 2005, doctors endorsed private health insurance.

The position paper released last month, the CMA's next step, has major limitations. The first problem is that it endorses the myth that publicly funded health care is unsustainable. The man who produced the most thorough study of Canadian health care in the past three decades, Roy Romanow, has declared that our

health care is as sustainable as we want it to be. Why?

In the past 15 years, publicly funded health care has grown parallel with the rest of the economy. In a picture that differs from almost every other developed country, Canadian public spending on health care as a proportion of the GDP remains at the same level as in 1992, under 7.5 per cent.

Furthermore, between 1997 and 2004, federal governments have devoted \$250 billion to tax cuts. If tax cuts weren't sacrosanct, and an appreciable chunk of that money were available for health care, the tub-thumping about unsustainability would sound very hollow indeed.

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MESSAGE TO THE CMA: CHOOSE PUBLIC INTEREST, NOT SELF-INTEREST(continued)

Second, in setting up its four options, the CMA neglected the choice made by the three key health-care reports of the past decade: the National Health Forum of 1997, the Romanow commission, and the study by Senator Michael Kirby.

All recommended a strengthening of publicly funded health care, with national home-care and pharmacare programs.

Recent recommendations from the Canada Health Council and the federal wait-list adviser, Brian Postl, have further reinforced the “strengthen Medicare” option. While lauding the initial progress in reducing waiting times, their recommendations have included training more doctors and nurses, modernizing health care through an electronic medical record and information technology, and effectively using the science of queuing theory to reduce waiting lists.

Aside from funding, the other part of the health-care puzzle is who should deliver care. Because the evidence has been less certain, previous authoritative reports have varied in recommendations regarding for-profit versus not-for-profit delivery.

Since 2002, five systematic reviews published in leading peer-re-

viewed medical journals have clarified the situation. Addressing hospitals, out-patient dialysis, and nursing homes, these comprehensive overviews of the available evidence all demonstrated poorer care, and poorer outcomes, in for-profit versus not-for-profit institutions.

Why do we pay more, only to receive poorer care, with for-profit delivery? Higher administrative costs, higher executive salaries, the requirement to pay taxes and, most important, the requirement to provide a return to investors means less money available for delivering care.

Sadly, this evidence, though uncontested in the scientific literature, has played a limited role in the health policy debates. The CMA has ignored it.

Why has the CMA so transparently tried to limit the debate, leaving the possibility of strengthening publicly funded care, delivered by not-for-profit providers, out of its list of options? An ideological commitment to a private-sector philosophy is one possibility.

Self-interest is another. For instance, the CMA’s president-elect, Brian Day, is an aggressive advocate of private-pay and for-profit delivery. He also earns his income from a

private for-profit surgical facility in British Columbia.

Canadian doctors are far from unanimous in rejecting the evidence-based choice for health care in our country. More than 1,000 medical students have signed a petition asking the CMA to support Medicare. Doctors in training, the Medical Reform Group, and the recently formed Canadian Doctors for Medicare have also called for strengthening publicly funded care, delivered by not-for-profit providers.

At its annual meeting in August, the CMA will have the opportunity to redeem itself by following the lead of these enlightened voices. Delegates can, for instance, select the more moderate physician who is now challenging Dr. Day for the presidency.

Can the CMA choose the public interest over self-interest? Will it turn to the best direction for our health care? Next month in Charlottetown, we will see. ♦

Published July 22, 2006 in the Globe and Mail on-line edition.

A DOCTOR IS ‘SADDENED’ BY THE CHOICES OF HIS PROFESSION

Gordon Guyatt

It has been 20 years since I have been so saddened and disappointed with the behavior of my profession as I was during the last week.

In 1984, then-Health Minister Monique Begin responded to the growing number of doctors opting out of Medicare, and charging their patients fees beyond what public insurance would pay. She saw that the

growing phenomenon was severely undermining Medicare, and leading Canada back to the 1950’s – or the U.S. style of medical care that existed at that time, and has existed ever since. *(continued on page 5)*

A DOCTOR IS 'SADDENED' BY THE CHOICES OF HIS PROFESSION (continued)

Begin's response was the Canada Health Act, one of the very few pieces of federal legislation passed unanimously by parliament. Provinces responded gradually to the act, which stipulated dollar-for-dollar penalties in federal transfers to the provinces that allowed user charges to patients for medically necessary physician and hospital services. But all eventually introduced measures to end the practice of extra-billing.

Doctors in Ontario responded to legislation making it illegal to bill patients for insured services with a province-wide month-long strike. Doctors lost that 1986 strike, and in the process demonstrated that they were out of touch with public values, not committed to equitable care for all the citizens of Ontario, and ready to put their personal financial interests above the interests of their less affluent patients.

For a time, Canada's doctors learned the lessons from the strike. For most of the last two decades, provincial and federal medical associations have been relatively quiet regarding the fundamental tenets of Medicare, implicitly lending support to universal, equitable access to high quality care.

At the recent Canadian Medical Association meeting, delegates have made the tragic choice of repeating a sad history. They chose a President-elect, Brian Day, who openly violates the Canada Health Act by allowing well-heeled patients to jump the queue at his private clinic, and uses rhetoric such as comparing universal health care to that of North Korea. They passed resolutions in support of private insurance, and doing away with rules that prevent

doctors from simultaneously taking advantage of public insurance and at the same time charging patients for quicker or better care.

Brian Day is now softening his down-with-Medicare rhetoric, and CMA delegates also passed resolutions expressing support for Medicare. Unfortunately, the policy choices in their resolutions, and in their choice of Brian Day as incoming President, leave no doubt about the organizations fundamental position. Were Canada to allow doctors to double-dip, and to allow private insurance for publicly insured services, it would mean the end of equitable health care for all Canadians, and a move back to a U.S.-style two tier system.

Fortunately, there are many Canadian doctors - perhaps the majority, polls leave the detailed views of the mass of physicians somewhat uncertain - whose views reflect Canadian values, and the evidence on the impact of a parallel private system, and for-profit delivery. That evidence has been carefully studied, and well articulated, in the Romanow report's definitive analysis of the options for Canadian health care.

Private insurance leads not only to inequities in health care that are unacceptable to the majority of Canadians, but to huge administrative inefficiencies. The U.S. experience has shown us that a parallel private system is a recipe for runaway health care costs, and a competitive disadvantage for large industries that must pay health benefits to their unionized employees.

Rigorous comparisons of for-profit versus not-for-profit hospitals and outpatient clinics have shown that

the requirement to provide profits to investors compromises care in for-profit facilities. In both hospitals and dialysis clinics, lower funding for care delivery results in higher death rates.

Doctors' organizations like Canadian Doctors for Medicare and the Medical Reform Group understand that evidence, and will continue to speak out on behalf of Medicare, and the interests of the Canadian public. But those voices from the medical profession may be overshadowed by the attention given to Brian Day and the CMA.

The CMA has placed itself in the same fundamental camp as the right-wing think tanks like the Fraser Institute and politicians such as Preston Manning and Mike Harris, whose clear goals are the destruction of Medicare. That destruction would serve the interests of only three groups: wealthy Canadians, doctors whose priority is maximizing their incomes, and investors interested in making profits from health care delivery.

Ordinary Canadians would find themselves at the back of the health care queue.

It is a sad day when Canada's leading medical association sets itself at odds with the interests of the public they should be serving. ♦

Published August 28, 2006, by The Hamilton Spectator.

MEDICAL STUDENTS ACROSS CANADA SPEAK OUT AGAINST TWO-TIER MEDICINE

Larissa Liontos, sMRG Toronto

It was one year ago this month, at the CMA's annual general meeting, that CMA delegates voted in favour of allowing private health insurance and private-sector health services when timely access to medical care is not available.

The CMA vote took place two months after the Supreme Court of Canada ruled in favour of Dr. Jacques Chaoulli and his patient, George Zeliotis, in a case that challenged the public health care system, saying that Canada's ban on private health insurance violates the rights of Canadians. The case opened the door for increased involvement of the private sector and private insurance companies in the provision of health care services in Quebec.

In response to the CMA vote, members of the student Medical Reform Group (sMRG) at the

University of Toronto decided to petition the CMA to reject a two-tier system that discriminates against lower income Canadians and to seek health care reforms within the public system.

The petition was written and circulated to the first and second year classes as well as to clerkship students during seminars (Previously described in the Spring MRG Newsletter). Through these means the sMRG collected 334 signatures at U of T alone. After collecting signatures from U of T, a decision was made to include medical students from across the country. The petition was made available online through a link on the student website: www.medicalreform.ca. To date, the petition has generated 1134 signatures and represents every medical school in Canada.

The student petition made national news this week when Jonathan DellaVedova, a first year medical student at NOMS and a board member with Canadian Doctors for Medicare, circulated the petition cover letter to delegates at the CMA meeting.

Unfortunately, Jonathan didn't get the opportunity to present the petition to new CMA president, Dr. Colin MacMillan, but plans are being made to contact the president at CMA headquarters in Ottawa. Nevertheless, Jonathan as well as other student MRG members had the opportunity to speak to several members of the media about the petition as well as express their disappointment with the election of privatization supporter Dr. Brian Day as the CMA president for 2007-2008. ♦

MEDICAL STUDENTS URGE CMA TO SUPPORT MEDICARE

Students from all 17 medical schools are urging the Canadian Medical Association (CMA) to support publicly funded, accessible healthcare. Organized by the Student Medical Reform Group (sMRG), 1,134 students signed a petition that unequivocally supported Medicare, and voiced disappointment with the August 2005 CMA vote in support of private sector involvement in healthcare delivery.

The petition is to be presented today to the President-elect of the CMA, Dr. Colin McMillan, at the CMA's AGM in Charlottetown.

"As future physicians, we are urging the CMA to commit to publicly funded Medicare, and oppose the introduction of private health insurance and the emergence of a two-tier system. We feel strongly that the ability to pay should not affect patient care", said Larissa Liontos, a third year MD/PhD candidate at the University of Toronto.

The petition quotes the CMA's own Code of Ethics, which demands physicians to "consider the well-being of society in matters affecting health" and to "promote equitable access to health care resources". The students also point out that two-tier healthcare

in other countries has increased wait times for those in the public system, and allowed those who can afford to pay for private insurance to jump the queue.

"As a new resident in downtown Toronto, I see patients every day who would never be able to afford private insurance", states Andrew Pinto, a Community Medicine physician-in-training. "My hope is that CMA members, who are our teachers and mentors, continue to support public medicine as the best choice for our patients". ♦

Released by the Student Medical Reform Group, Monday, August 21, 2006 in Charlottetown.

MEDICAL STUDENTS URGE CMA TO SUPPORT MEDICARE (continued)

TEXT OF THE PETITION

We, the undersigned Canadian medical students, recognizing our future role as physicians and our duty to be advocates for our patients[1], urge the Canadian Medical Association (CMA) to support publicly funded and accessible medicine. We were disappointed to see CMA delegates vote on August 17, 2005 in support of allowing private health insurance and private-sector health services[2].

As outlined in the CMA Code of Ethics[3], we are required to “consider the well-being of society in matters affecting health” and “recognize that community, society and the environment are important factors in the health of individual patients”. It is our duty to respond to challenges to our system such as the June 9, 2005 decision by the Supreme Court of Canada in the “Chaoulli case”, striking down the prohibition of private health insurance[4]. The Code of Ethics also calls us to “recognize the responsibility of physicians to promote equitable access to health care resources”. Patients should not be “discriminate[d] against on such grounds as age, gender, marital status... or socioeconomic status”.

The ability to pay for private insurance should not enter our decision making process and affect the type of care we give. Physicians should be involved and vocal in ensuring our society grants all citizens the right to health care.

Two-tier medicine with a parallel private health care system threatens this right. Patients who can afford to pay for private health

insurance will be able to jump the queue. Access will not be based on need, but on socioeconomic status. Some may argue it is a violation of human rights to prevent individuals who can afford it from seeking more rapid care. However, we feel it is no more just to create a barrier to care for those who cannot afford to pay. In addition, Canadian examples show that the private system will take physicians away from serving the public system[5]. Evidence demonstrates that wait times in the public system increase when there is an existing private system[6].

The Kirby and Romanow Commissions cautioned against this move towards two-tier health care delivery. The majority of Canadians consistently put accessibility for all ahead of more rapid access for those who can pay out of pocket[7,8].

- ◆ We firmly support the Canada Health Act principles of universality, comprehensiveness, accessibility, portability and public administration.

- ◆ We urge the CMA and its members, who are our mentors, teachers and supervisors, to support public medicine.

- ◆ We disagree with the motion passed at the CMA Annual General Meeting, stating that patients who can't get timely access to care should be allowed to rely on private health insurance and private-sector health services. We feel strengthening the public system should be the CMA's priority, as it was in 1995.

In conclusion, we do not want to be the generation of physicians who practices under a two-tier or private healthcare system, and feel that publicly funded and accessible health care is the best for the health of our

future patients. As the CMA has stated previously, “It is in the interest of all Canadians to have a publicly funded health care system where access to health care is based on need, not the ability to pay”[9]. ♦

Sincerely, The Undersigned

Original petition signed by 1,134 students at 17 medical schools across Canada

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THE STRUGGLE CONTINUES ... AN UPDATE FROM HEALTH PROVIDERS AGAINST POVERTY

Gary Bloch

Health Providers Against Poverty is a group of diverse, activist health providers working to bring an end to the health effects of poverty, the most powerful determinant of health. Since our explosive start last summer, with the Special Diet campaign, that forced the government to devote millions of dollars to alleviating the poverty experienced by Ontario's most vulnerable citizens (well documented in the last year's worth of Medical Reform newsletters), we have remained active on a number of fronts.

We have been gaining profile as an increasingly powerful and respected voice on health and poverty. Our current activities include:

1. Lobbying of the provincial government to treat poverty as a health emergency. Both Sheela Basrur (the Ontario Chief Medical Officer of Health), and George Smitherman (the Ontario Minister of Health), in recent face-to-face meetings, expressed interest in pushing the Ontario government to prioritize poverty reduction in policy and program development. This comes on top of a successful municipal campaign that resulted in Toronto City Council endorsing an action plan for raising social assistance rates.
2. We launched a complaint with the provincial ombudsman, Andre Marin, to examine the devastating health effects a decade of severe cuts to welfare have had on our province's poorest citizens.
3. We continue to garner the support of health professional organizations. So far, we have the endorsement of the Registered Nurses Association of Ontario, the Ontario College of Family Physicians, the Toronto Board of Health, the Association of Local Public Health Agencies, and the Ontario Public Health Association, among others. We are in active discussions with the Ontario Medical Association to include poverty (alongside smoking and obesity) as one of its key health priorities.
4. We continue to work with other anti-poverty groups to join forces in direct action and lobbying campaigns to raise public awareness and pressure the government to live up to its campaign promises to reduce poverty. We have found the health perspective is a powerful addition to these campaigns. Our next big action will take place in late October, to mark the International Day of Action Against Poverty.
5. We are awaiting the results of a negotiated settlement by the privacy commission of Ontario to a complaint we launched regarding changes the provincial government made to the special diet supplement application form. These changes force recipients (through their physicians) to reveal their medical information to non-health worker, front-line, social service workers, essentially creating a two-tier system of health information privacy rules based on income.
6. We filed a submission with the Special Diet supplement expert review committee, arguing that they should include poverty as a

recognized health condition, which would allow physicians to prescribe an income supplement to alleviate the health (and nutritional) effects of poverty.

This work is gratifying, frustrating, and often extremely exciting. Of course, the struggle against poverty is centuries old, but health providers (despite overwhelming epidemiological evidence in support of the link) have been notoriously inconsistent in their recognition of the need to treat poverty as a health issue. The interest is there, however, as evidenced by the support we've received from health providers, health organizations, anti-poverty groups, and even some key figures in government.

We are always looking for support from other health providers. We have a small but very active core group, and a much larger, often passionate, group of supporters. If you are interested in joining our list serve, or in active involvement with HPAP to any degree, please do not hesitate to contact gray.bloch@utoronto.ca. And keep your ears open for our next call to action! ♦

ONTARIO RAISE THE RATES LOBBY

Health Providers Against Poverty has been actively seeking opportunities to disseminate a simple message, as noted in the following letters, to the Special Diet Expert Review Committee of the Ontario Disability Support Program of Ontario Community and Social Services on evidence-based submissions for consideration by the Special Diet Form Expert Advisory Committee, June 5th, 2006, and to Andre Marin, the Ombudsman of Ontario, May 5th, 2006 on the inequity of the government's treatment of poor people.

I am writing on behalf of Health Providers Against Poverty to ask that "Poverty" be included as a medical condition in the Special Diets Schedule.

There is clear evidence in the medical literature linking poverty to morbidity and mortality from many serious medical conditions, including heart disease, diabetes, and severe mental illness. Attached, please find a referenced summary of the evidence linking poverty, health and nutrition. In addition, please find a document prepared by Toronto Public Health entitled "The Cost of a Nutritious Food Basket in Toronto – 2004" that details the cost of a basic nutritious diet in Toronto.

It is our opinion that the diagnosis of Poverty should be added to the Schedule; this diagnosis should mandate a special diet consistent with the Nutritious Food Basket as described by Toronto Public Health. The analysis by Toronto Public Health states that a single person receiving Ontario Works needs \$285.43 per month beyond his or her social assistance cheque to afford to purchase the Nutritious Food Basket while living in market rent accommodation. As per this analysis, we are asking that the committee recommend that every person on social assistance who is diagnosed with Poverty receive the maximum allowable \$250 per month through the special diet supplement program, to enable them to afford to purchase a basic nutritious diet. Without the ability to afford a basic nutritious diet, we feel discussion of other "special diets" are unlikely to be of benefit to recipients' health – it is hard to believe a person with heart disease will use their extra supplement to buy a "heart-healthy" diet when they are struggling to buy bread and milk.

We realize that a better solution to the poverty of people on social assistance is to raise social assistance rates themselves by the needed 40% and we hope that you will join us in lobbying the provincial government to that effect. But, until social assistance rates are raised, including Poverty as a medical diagnosis in the Schedule will allow health providers to directly improve the morbidity and mortality of impoverished social assistance recipients by prescribing them money for a healthy diet.

We thank you for considering our submission. If you have any questions, please do not hesitate to contact me at tara.kiran@utoronto.ca or at 416-203-4507. ♦

We are writing to you as health professionals from across the province who provide health care, collectively, for thousands of the poorest Ontarians. We are deeply concerned about the threat poverty poses to the health, well-being, and lives of those in our care. This poverty is preventable and reversible, but a succession of governments in Ontario have made cuts to social programs that have resulted in an increase in our patients' poverty and a corresponding worsening of their health. It is this legislated poverty that we feel falls within your mandate to investigate.

Ontario Works and Ontario Disability Support Plan benefits were drastically cut in 1995, and have fallen steadily relative to inflation since then. Welfare recipients' spending power is now forty percent less than it was prior to those cuts. This has left our patients on social assistance without enough money to pay for even their most basic needs, such as food, shelter, and childcare. The Toronto Board of Health estimates that a single person receiving Ontario Works benefits receives only about two-thirds of what she requires to meet her basic needs. People cannot be healthy when they are forced to choose between food and rent and keeping the heat on. We feel this situation constitutes an unconscionably under-addressed health crisis.

A recent example of the provincial government's neglect of Ontarians living in poverty occurred with the changes to the Special Diet Allowance application process. This Allowance was created to provide a nutritional supplement for people living on welfare who require nutritional support for the treatment or prevention of health problems. In November, 2005, the government arbitrarily revised the application criteria in a manner that cut

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HIGH COSTS AND HARD CHOICES

Ahmed Bayoumi offers this timely contribution to the on-going debate at the Steering Committee in the context of our discussions on a National Pharmacare Strategy, a potential charter challenge on Direct to Consumer Drug Advertising, as well as Ontario's Bill 102 and its support for hospital administration of privately purchased therapies. Members are invited to comment, either in writing to the address on the masthead or electronically to medicalreform@sympatico.ca

Consider bevacizumab (Avastin®). It is a novel anti-cancer drug, a recombinant monoclonal antibody that inhibits angiogenesis (new blood vessel growth). The main current indication is for people with metastatic colon cancer, a terrible disease. Only 12 per cent of patients are alive 5 years after diagnosis; without treatment, the median life expectancy is 6 months.

With current chemotherapy regimens, life expectancy is about 10 to 16 months. In several trials, bevacizumab increases life expectancy beyond current chemotherapy regimens by about 4 to 6 months. It's also associated with more adverse events, so there are some trade-offs that patients considering this new drug have to make.

There are also trade-offs for governments and hospitals that have to pay for bevacizumab. The Patented Medicine Prices Review Board lists the cost at \$125 for a 25mg/mL injectable solution; a typical single use 400 mg vial would cost \$2,000. According to the UK's National Institute for Clinical Excellence (NICE), the average number of treatments was 18.2.

Hence, the cost to treat a single patient would be about \$36,400 in Canada. Multiply that by the number of people with metastatic colon cancer, and you have a budget out of control. One recent study estimated that bevacizumab and similar drugs would increase the cost of cancer treatment by about 21 per cent.

Given the complexity of manufacturing this drug, there may

never be a low cost generic equivalent. And there are more drugs like these on the horizon. These drugs (and there are similar examples in other diseases) pose hard questions. Should governments fund these sorts of drugs? How will such decisions be made?

The usual way funding agencies approach decisions like this is to examine the cost effectiveness of the drugs – an economic method that looks at the cost relative to the benefit. A back-of-the-envelope calculation suggests that the cost effectiveness ratio for bevacizumab is going to be in the range of \$70,000 per life year gained (a cost of about \$35,000 per patient, an increased life expectancy of about half a year). More sophisticated models take into account a number of other factors, including quality of life, and report health benefits as a “quality-adjusted life year” or QALY.

The QALY model remains controversial, but has been widely adopted. Many authorities suggest that interventions with cost effectiveness ratios above \$50,000 per QALY (some would peg the number higher at \$75,000 or even \$100,000) are not cost effective.

NICE's preliminary analysis suggests that the cost effectiveness of bevacizumab is about £60,000 to £90,000 per QALY, which is about \$125,000 to \$190,000 per QALY in Canadian terms. These numbers suggest bevacizumab is not cost effective. That is, prescribing bevacizumab is an inefficient use of resources, a poor return on investment. Those

sound like harsh terms when talking about human lives and they are.

As someone who performs and evaluates cost effectiveness studies, I think there is value in these sorts of analyses in presenting decision makers with synthesis of quantifiable evidence with which to make decisions. But there are at least four reasons to view these sorts of analyses carefully and contextually.

First, many drugs come to market before they have been fully evaluated clinically. In bevacizumab's case, there were several trials documenting survival benefits, but such is often not the case. A new and expensive class of diabetes drugs was approved based on short-term data about blood sugar control. In many instances, the evidentiary base for making decisions is scant or incomplete.

Estimating cost-effectiveness from such short-term data requires extrapolations and assumptions. That's not necessarily bad, but it can lead to a couple of unfortunate outcomes. Analysts may not adequately reflect the inherent uncertainty in such models, making over-confident assessments when more research is needed. Decision makers, conversely, sometimes focus on the uncertainty as an excuse for inaction.

One solution to such an impasse would be to issue interim funding decisions, tied to future research findings or the development of effective alternatives. Unfortunately, most decisions tend to be less creative and focus solely on the “fund or not” decision.

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HIGH COSTS AND HARD CHOICES (continued)

The second reason to be thoughtful about how cost effectiveness analyses should be applied is that, by necessity, almost all analyses require some component of modeling. Accordingly, an analysis is only as good as its underlying model. The problem with the drug approval process is that virtually all models are developed or sponsored by the manufacturer.

Several studies of published analyses indicate manufacturer-sponsored assessments tend to be more optimistic than those of independent evaluators. Whether this relates to unpublished evaluations is unknown, but one might reasonably expect that the discrepancy could be even greater. Even worse, manufacturer's submissions are deemed proprietary, meaning that they are available for confidential review by the funding agencies and its evaluators, but not available for public scrutiny.

NICE has started to do its own evaluations alongside some manufacturer's submissions and to publish some components of the evaluations, but this trend needs to go much further and to be evaluated. Simply put, we need an analysis of the cost effectiveness of doing independent cost-effectiveness analyses! By analogy, look to the drug approval process in the United States (where evidence submitted for drug approval enters into the public domain). It is through examination of public records, not manufacturer-sponsored trials, that disturbing information about the safety and efficacy of Cox-2 inhibitors became known.

The third reason to be concerned about cost effectiveness analyses is that they focus solely on questions of efficiency, but not on the impact of budgets. Ontario requires

manufacturers to include an assessment of a decision on the health care budget, but there are few guidelines by which to judge the quality or accuracy of such assessments. This becomes particularly important if we pose the cost question another way – not “How much will the budget have to increase to cover this new drug?” but rather “What will we not be able to do if we cover this new drug?”

Although the tendency here might be to take a managerial perspective and focus on the drug acquisition budget (“What drugs won't be covered?”), it's useful to go all the way “up the ladder” of consequences and reflect on the trade-offs made in social spending more generally. What other health care interventions won't be covered? What about other social spending (such as education or welfare – it's also useful to ask who wins and who loses)?

Going all the way up the ladder might lead one to ask whether it is worthwhile to increase taxes to increase social benefits. Given the relentless tax cuts of the 1990's, that's a very good question to ask. Of course, this argument can also work in the opposite direction – an expensive, and perhaps even inefficient, therapy may have a very limited use and consequently, very little budgetary impact.

Finally, the QALY model offers some unique challenges. One of the most important is that the model makes no distinction regarding who is accruing the benefit. While society might rightly refuse to discriminate on many grounds between individuals, one area where ethicists and the public both agree is that the sick should be given higher priority over the healthy when it comes to funding decisions.

Although there are a variety of methods to address these concerns, one transparent approach is to use a different cost effectiveness threshold for different groups of people, implying that society would be willing to spend more to gain a QALY experienced by somebody with metastatic cancer than by somebody with, say, acne.

The incorporation of such concerns into economic analyses is still an area of methodological research, but the fact that such analyses are being used for treatment decisions mandates those who produce and consume such analyses to think hard about whether the resulting conclusions are equitable. It is not difficult for me to accept that we should have a higher cutoff for people with severe illnesses when it comes to funding decisions (although I'm not yet sure where that cutoff should be).

There are many more questions that I haven't discussed, including the question of what constitutes a just process of decision making (Who gets to sit at the table? What process ensures that everybody is part of the decision?) and how to determine what is a “fair” price for drugs? (In fact, it is exceedingly difficult to find out how much of a drug's cost represents true development costs, which may be heavily publicly subsidized, and how much represents profits. The observation that pharmaceutical manufacturers are, as a group, very profitable is likely telling).

Cost effectiveness offers useful information for decision making, but like all tools and frameworks, its limitations need to be explicitly considered. For reasons mentioned above, such analyses may not always represent the final word on efficiency.

(continued on page 12)

BILL 102—BIG PHARMA WINS AGAIN

Norman Kalant

In April of this year the Minister of Health introduced Bill 102, with the obvious goal of reducing expenditures on drugs. This was to be accomplished by three separate processes.

First, the Drug Benefit Plan would be directed to use its large buying power as leverage during negotiations with pharmaceutical producers, to obtain lower prices.

Second, pharmacists would be given more opportunity to substitute generic products for the more expensive brand-name products. The vagueness of the wording led, in some quarters, to concerns about the exact meaning of “similar” and “same” in relation to pharmaceutical actions, and whether either would lead to reference-based pricing as in B.C. At the same time the large rebates given to pharmacies by the generic manufacturers would be prohibited.

HIGH COSTS AND HARD CHOICES (continued)

Compared to other areas of clinical research, such analyses will inherently have more associated uncertainty and are open to manipulation. Sometimes there is not much uncertainty and cost effectiveness analysis yields a good measure of efficiency. Even then, from the perspective of fairness, it may often be desirable to sacrifice some efficiency to advance equity. There are no fancy technical solutions to hard political choices. ♦

Third, Generics would be subject to price regulation so that they would be available at cost significantly lower than those for name-brand drugs.

The immediate response of “Big Pharma” was a threat that any attempt to control their profitability would lead to “disinvestment” in Ontario: they would pull up stakes and move their operations to more welcoming jurisdictions. Ontario would lose all their R&D expenditures, and all the associated jobs. There was an outcry from the pharmacists, also, particularly the small independent entrepreneurs in rural and semirural locations, arguing that the loss of rebates from the generic producers might mean bankruptcy for them, unless they were compensated by an increase in other payments.

Following second reading in the legislature, Bill 102 was sent without delay to the Committee on Social Policy. Those who had asked for an opportunity to address the Committee were notified of the date of their appearance, usually with only a few days to prepare. Drs. Joel Lexchin and Norman Kalant appeared on behalf of the Medical Reform Group.

Dr. Lexchin described his extensive experience in preparing and teaching guidelines for the use of drugs, to medical students and practicing physicians. He reassured the Committee that generic substitution and therapeutic substitution do not have negative health outcomes, and the terminology used (same or similar) is unimportant. He then discussed another issue, namely the threat that the drug manufacturers would abandon Ontario if the government persisted with Bill 102. This threat

has been a standard response for many years; since the industry’s profit level remains high, and would not be greatly affected by the proposed legislation, it is highly unlikely that it would be carried out.

Dr. Kalant continued with this theme by describing a recent study of the research produced by the R&D expenditures which the companies claim to be making each year. Before the period of patent protection was extended in 1993, the industry argued that it needed longer patent protection to increase its revenues and thus have more money to invest in R&D.

In fact, although R&D spending did increase, the rate of introduction of new drugs did not. He then used the number of scientific publications and the number of patent applications, per year, as outputs of their research, to compare the Canadian subsidiaries with their own parent firms in the US. The subsidiaries produced far fewer outputs per \$1000 of R&D expenditure than the parent firms (there was one exception to this finding).

If the money claimed as R&D does not produce new drugs or new knowledge (expressed as scientific publications or patents), where does it go? Even if the industry does withdraw from Ontario the loss to the province may not amount to much.

The major innovations associated with Bill 102 in the form ultimately approved in the legislature, are the following. (1) It establishes the position of executive officer of public drug programs and makes him responsible for deciding which drugs are “interchangeable” (drugs with the same or similar active ingredients in

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COURT CHALLENGE OF DIRECT TO CONSUMER DRUG ADVERTISING

Steven Barrett provided the following status report on the CanWest Media challenge and opportunities for intervention.

As you know, Can West Media Works has challenged a federal ban on direct-to-consumer advertising (DTCA) of pharmaceutical products. They say the ban offends the free speech guarantees of the Charter. If Can West succeeds, the result will defeat a key objective of the National Pharmacare Strategy being advocated by several CLC affiliates.

The Strategy, calls for tougher regulation of drug promotion and marketing activities.[Note:1] As the evidence shows, if DTCA is allowed more people will visit the doctor, and

demand for drugs, especially name-brand products, will go way up. The result will significantly increase overall health care system costs, as well as the cost of employee drug plans. As we know, increasing drug costs have already created real cost pressure to reduce drug plan coverage to workers and retirees.

The case is currently being formulated at the trial level before the Ontario Superior Court of Justice. It is common for public interest interveners to wait for the appeal stage before applying for leave to participate in a case. However, in this instance, there are good reasons to do so at the trial level.

First, it is at this level that the evidentiary record is formulated. This record, and the findings of fact based upon it, may be critical to a decision years later by the Supreme Court of Canada. If the interests of workers, consumers, women and other groups are to be properly considered, it is important to ensure that a proper evidentiary foundation for this is laid at the first level.

Second, it is not clear how vigorously the current federal government will defend this crucial private sector regulation, and we understand that it may ignore or put very little emphasis on the issue of health care system and benefit plan costs.

Third, there are several groups that are interested in intervening in the case. Assuming some interventions are allowed, it may be difficult to get into the case at a later date.

Finally, if the drug companies or others supportive of removing the ban decide to intervene, it will be

important to counter their influence. ♦

MAKING THE LINKS

Hamilton Member Rachelle Sender reminded Spectator readers July 18th, 2006, in response to a July 13th editorial, Our hearts could be healthier.

The fact that Hamilton has the worst heart health in the country is no mystery; surely it is related to the astronomical rates of poverty found in this city, as detailed in the Spectator's Poverty Project. Indeed one of the articles in this series ("Poverty, obesity go hand-in-hand", November 5, 2005) documents exactly this link.

In the July 13 article Dr. Greg Curnew is quoted as saying that "It (turning things around) starts with eating better - by replacing junk food with more fruits and vegetables". Surely this is blaming the victim. No doubt many people on social assistance would love to buy more fruits and vegetables but are unable to afford them on the inadequate income they receive. The provincial government has recently made the situation even worse by cutting make on the supplemental allowance people used to receive in order to improve their diet.

Clearly in order to improve the heart health of Hamiltonians we need to look beyond medical, or even life style, issues and try to tackle the issue of poverty and inadequate rates for social assistance. ♦

BILL 102—BIG PHARMA WINS AGAIN (continued)

the same or similar dosage). In addition, most of the duties and powers of the Minister with regard to the Ontario Drug Benefit Act are transferred to the executive officer. Among these duties are updating the Formulary and determining the price of listed drugs. (2) A Citizens' Council and a Pharmacy Council are established to advise the executive officer. (3) Offering or accepting rebates by manufacturers and other suppliers of drugs to pharmacies is prohibited. The proposal to use the buying power of the government to lower drug costs has disappeared as the pharmaceutical industry again demonstrates its economic power. ♦

NATIONAL PHARMACARE STRATEGY A HARD SELL WITH PREMIERS

The Medical Reform Group sent this letter July 5th, 2006 to the Ontario Premier in advance of the Premiers' meeting slated to review premiers' progress on the National Pharmacare Strategy.

We are writing to address two issues with you in anticipation of the Ministerial Task Force report on the National Pharmaceutical Strategy, and on the eve of your upcoming Council of the Federation meeting in St. John's, July 26-28, 2006.

1. Pharmacare and the National Pharmaceutical Strategy:

Key messages:

Real progress on the National Pharmaceutical Strategy is urgent. Public health is being endangered and Canadians are not getting value for money. It is time to put adequate drug coverage in place. Canadians need an actual plan, with clearly specified target dates, and a strategy for implementation.

Canadians expect their federal government to be at the table as a full partner, including sharing in the costs of providing for those currently going without drug coverage. We will work with you to help secure appropriate federal involvement.

Canada has a serious problem of drug over-spending, misuse, and under-insurance:

- Drug over-spending: 8 to 10 per cent increases in drug costs after inflation since 1990's - \$2.1 billion spent by drug industry on promotion in 2004
- Drug misuse: 12,000 deaths per year in Canada from Adverse Drug Reactions; 347 per cent increase in antidepressants (SSRIs in women and children)
- Drug under-insurance: 4.3 million Canadians have inadequate drug coverage; 600,000 Atlantic Canadians have no drug coverage

International research indicates that drug companies engage in large scale marketing malpractices, "ranging from covertly attempting to persuade consumers that they are ill to bribing doctors and misrepresenting the results of safety and efficacy tests on their products." (Sarah Boseley, "Drug firms a danger to health – report", *Guardian UK*, June 26, 2006).

If pharmaceutical industry malpractices go unchecked and Health Canada permits more direct-to-consumer drug advertising, this will:

- 1) threaten the sustainability of Medicare with new drugs that are more expensive but no better than existing ones;
- 2) threaten Canadians' health with unsafe drugs;
- 3) pose a barrier to access for seniors, retirees, and the working poor;
- 4) fuel pressure for privatizing health care service delivery and coverage;
- 5) shift employer drug benefit costs onto workers;
- 6) undermine the competitive advantage for Canadian manufacturers; and
- 7) crowd out other health care spending (for example, home care, primary care reform)

We refer you to the comprehensive strategy recently prepared by the Canadian Health Coalition, which proposes that Medicare cover essential drug costs in the same way it now covers hospitals and physicians (www.healthcoalition.ca/moreforless.pdf). The solution is to expand public drug insurance and pay only for cost-effective and safe drugs.

2. Wait Time Solutions in the Public System:

Key message:

Care guarantees are misguided and divert scarce resources away from public hospitals to investor-owned, for-profit facilities. This distracts from the real task of fixing the public health care system and encourages the establishment of a private parallel health care system. We encourage you to continue working on public solutions to wait time problems including better management and coordination of wait lists, as outlined by the Federal Advisor on Wait Times, Dr. Brian Postl.

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NATIONAL PHARMACARE STRATEGY A HARD SELL WITH PREMIERS (continued)

Countries with parallel public and private healthcare systems have longer waiting times in the public system than countries with a single-payer system, such as Canada. Turning to private for-profit clinics doesn't make sense — more private facilities do not mean more healthcare providers. The private system doesn't train nurses or doctors; the ones they hire come from the public system. Care guarantees have been tried and abandoned in Norway, Sweden and Denmark because they failed.

The issue is how to manage wait lists to ensure that patients get care at the right time.

Switching the criterion for moving to the front of the line from need to length of time on a wait list is bad for patients. It is important to distinguish between *guarantees*, which are likely to prove destructive, and wait time *benchmarks* associated with rigorous monitoring. Setting guidelines for acceptable wait times, and keeping close track of how we are doing in achieving them, is highly desirable.

More market-based health care and private insurance will not solve wait time problems or unsustainable drug costs — they make them worse. Private health insurance and delivery is more expensive, inefficient, inequitable, and of lower quality. It's time to build on the success and compelling advantage of Canada's single-payer public insurance programs. ♦

cc: Hon. George Smitherman, Ontario Minister of Health and Long-Term Care
Ontario Health Coalition
Canadian Health Coalition

A STATUS REPORT FROM THE PREMIERS' MEETING FROM BC GOVERNMENT

Canadian Health Coalition Director Michael McBane shared an August 8th message from the BC government representative on the Premiers' deliberations

I'm writing to provide you with an update on the status of the National Pharmaceuticals Strategy (NPS).

As you may be aware, the NPS Progress Report was completed in June, 2006. It provides an overview of progress on the five key elements of the NPS (Catastrophic Drug Costs, Expensive Drugs for Rare Diseases, Pricing and Purchasing, Common Formulary, Real World Safety and Effectiveness). It makes recommendations in each of these five areas, and outlines next steps, including the role of stakeholders in developing the next phase of the NPS.

The report was presented to provincial and territorial. Health

Ministers on July 5, and I'm pleased to report that the report, recommendations, and next steps were accepted. Health Ministers instructed the NPS Secretariat to transmit the report to First Ministers, and on July 28, Premiers also accepted the report and recommendations. They further instructed Health Ministers to continue work on key elements of the NPS, with special focus on catastrophic drugs.

Premiers directed Health Ministers to publicly release the report by September, and urged the federal government to continue to work with provinces and territories to develop and implement the strategy. The NPS Secretariat is now preparing the report for public release, and you can

expect to receive formal communication about the process shortly.

Thank you for your interest in the National Pharmaceuticals Strategy. ♦

Andrew van der Gugten
Executive Director
National Pharmaceuticals Strategy Secretariat
BC Ministry of Health

MONITORING ACCOUNTABILITY ON ABORTION

The MRG Reproductive Health Committee wrote recently to Premier Lord of New Brunswick to encourage his compliance with the Canada Health Act. His staff acknowledged our letter August 11, 2006.

MEDICAL REFORM GROUP

Box 40074, Toronto, Ontario M6B 4K4

July 31, 2006
Hon. Bernard Lord,
Premier of New Brunswick
P. O. Box 6000
Fredericton, NB E3B 5H1

Hon. Brad Green QC, Minister of Health
Government of New Brunswick
Box 5100, Carleton Place
Fredericton, NB E3B 5G8

Dear Premier Lord and Minister Green:

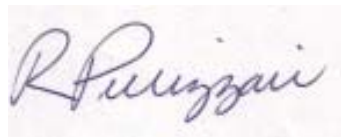
I am writing on behalf of the Medical Reform Group to urge you and your government to carry out your responsibilities under the Canada Health Act, which include the provision of timely abortion services.

Women of New Brunswick, as elsewhere in the country, are entitled to medically safe abortions covered by Medicare. We believe that your government's requirement for public funding of abortions which obliges women to have the written approval of two physicians and have the procedure performed by a gynaecologist in a hospital compromises access for those most likely to need the service. We also believe that this is inconsistent with the spirit and intent of the Canada Health Act.

We are concerned at the failure of your government to address the continuing harassment of women who seek the assistance of the Morgentaler Clinic in ending their pregnancies.

We are calling on you to announce a plan for accommodating the needs of New Brunswick women seeking abortions since the end of the Chalmers Hospital program in Fredericton, as promised by Minister Green. ♦

Sincerely,



Rosana Pellizzari, MD FRCPC

cc. Prime Minister Stephen Harper
Hon. Tony Clement, Minister of Health, Government of Canada

(416) 787-5246 [voice]; (416) 352-1454 [fax]; medicalreform@sympatico.ca; www.hwcn.org/link/mrg

ONTARIO RAISE THE RATES LOBBY (Marin letter, continued)

thousands of deserving people off this lifeline of extra income, and took millions of dollars out of the pockets of people living in extreme poverty. The new application forms require that medical conditions, including HIV/AIDS, be disclosed to front-line social service workers, which we consider a breach of privacy rights. The amounts that people receive for each health condition is grossly inadequate; for example, those with liver disease or cardiovascular disease only receive \$10 per month. Finally, the new regulations remove the ability for providers to promote a preventative approach to health care. This means that recipients are only eligible for assistance when significant damage to their health has already been done. The changes in this process were made without any basis in medical evidence, have undermined the purpose of this program, and have placed thousands of Ontarians at higher risk of developing, and suffering worse consequences from, significant health problems.

The change to the Special Diet Allowance program represents only one small example of the way in which our government has the ability to legislate poverty. Every day in our practices we see the negative health outcomes that result from living on social assistance payments that fall far below subsistence levels. A robust body of research supports the link between poverty, ill health, and premature death. People who live in poverty are at significantly higher risk for developing, getting sicker from, and dying from many diseases, including diabetes, cancer, heart disease, and serious mental health conditions. Furthermore, growing up in poverty can mean not growing up at all: a large-scale British study recently reported that the poorest children were 40% more likely to die in their first 10 years than children in the highest socio-economic group. The fiscal argument, that we need to “trim” social spending that has grown beyond our means, does not account for the inevitable and large increase in health care spending that will result from these policies.

Your office has consistently acted to protect the rights of our most vulnerable citizens. You carefully documented the plight of families who were forced to give up parental rights so that children with severe disabilities could access needed care, you recommended that government fund cysteamine for Batten’s Disease for Christopher Comeau-D’Orsay, and criticized the failures of Ontario’s newborn screening program that resulted in as many as 50 children annually becoming disabled or dying. In all these cases, government policies and programs caused suffering and harm to vulnerable Ontarians. We urgently request that you continue to use the powers of your office to protect those who most vulnerable by launching an investigation into legislated poverty in this province, especially chronically inadequate (and falling) social assistance rates.

We would like to meet with you to discuss our concerns about the health impacts of low social assistance rates and related programs such as the Special Diet Allowance. We would be pleased to provide additional information to support your investigation into this threat to the health of the hundreds of thousands of Ontarians living in poverty.

We look forward to your reply. Please contact Lynn Anne Mulrooney at 416 408-5616 or lmulrooney@rnao.org or 158 Pearl Street, Toronto, ON M5H 1L3. Thank you. ♦

[signed by HPAP Steering Committee members]

Gary Bloch, MD, CCFP, St. Michael’s Hospital

Mimi Divinsky, MD, Family Physician

Anne Egger, RN(EC), Regent Park Community Health Centre

Kathy Hardill, RN(EC), Regent Park Community Health Centre

Sarah Innis, RN, Street Health

Tara Kiran, MD, Regent Park Community Health Centre

Melissa Melnitzer, MD, CCFP

Lynn Anne Mulrooney, RN, MPH, PhD, Registered Nurses’ Association of Ontario

Alicia Odette, RN, Street Health

Neena Prasad, MD, CCFP, St. Michael’s Hospital

Deborah Phelps, RN, Central Toronto Community Health Centres

PLUS ÇA CHANGE—REFLECTIONS ON 1986

Janet Maher

Twenty-five members marked the 20th anniversary of the Ontario Doctors' Strike the evening of June 24th, 2006 in downtown Toronto.

The so-called doctors' strike refers to a summer of threats and work stoppages by Ontario physicians, predominantly in the Toronto and Golden Horseshoe areas in the face of Bill 94, the Ontario Health Care Accessibility Act, introduced in the fall of 1985 by the then new Liberal government. The bill was introduced mainly to bring Ontario in line with the federal Canada Health Act, passed the previous year, and intended to penalize provinces which allowed extra billing.

The spring of 1986 provided an opportunity for the Medical Reform Group to focus public attention on the issues that had originally brought them together for the Hall Commission in 1979. The MRG brief on Bill 94 to the provincial legislature standing committee on social development addressed most of the OMA and Association of Independent Physician arguments against the legislation directly.

Recommendations included better grievance procedures between the government and the OMA, an amendment of Bill 94 to avoid the requirement that patients pay opted

out physicians before being reimbursed by OHIP, better information on and support for alternative service models and a royal commission on the financing of health care.

The government of the day spent much of the spring of 1986 attempting to gather support for the bill, in the face of frequent demonstrations and study sessions well advertised to Queen's Park. Among the participants were three panelists who participated in the events of 1986.

Journalist Ann Silversides, who was at the time of Bill 94 a Globe and Mail reporter, thanked the group for the opportunity to review the events of 1986 and the reaction of media at the time. Her main observations focused on comparisons to some of the more current debates around Chaoulli and the relatively limited role of evidence in the various

debates both currently and 20 years ago.

Michael Rachlis shared some of the video footage he had captured along with anecdotes of debates and confrontations with then OMA president Dr. Earl Myers, and an analysis of the rather limited participation in the strike revealed by subsequent analysis of OHIP billings.

Philip Berger also gave a first person account, summarizing his presentation with a series of rules of conduct for the MRG which he thought had served the organization well over its history: be clear on the analysis, pick targets strategically and speak the truth.

Rosana Pellizzari, a student in the summer of Bill 94, wound up the evening by circulating lyrics of some songs adapted for the events of 1986, and leading the group in song. ♦



Toronto Star Editorial Page, July 1, 1986.

PANZI HOSPITAL CAMPAIGN UPDATE (continued)

tics, urgently needed for the development of future program directions. In the volatile region of eastern Democratic Republic of the Congo, where tens of thousands of women and girls have been brutally raped, the consequences on the health of the country are far-reaching. Currently there is evidence to suggest that rebel

soldiers from Rwanda and Uganda, infected with HIV/AIDS, used rape to deliberately transmit the virus in an effort to decimate the population. An assessment of the patient population within the catchment area of the Panzi Hospital is critical to the understanding of the health care needs in this region.

To support the Panzi Hospital Campaign or for more information, please visit www.medicalreform.ca/congo. ♦

MRG MEMBERSHIP APPLICATION

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

Membership Fees

- \$245 Supporting Member
Physician
Affiliate (out of province) physician
- \$60 Intern / Resident / Retired / Part-time
Organization
Newsletter Subscriber
E-Newsletter Subscriber
- Free Medical Student /
Medical Research Student

Please specify membership category:

Please specify areas of interest and expertise:

Name _____
Address _____
City _____
Province _____
Telephone _____
Fax _____
E-mail _____

Please charge my MasterCard/VISA in the amount \$ _____. My credit card account number is: _____
Name of Card holder: _____
Expiry Date: _____

Mailing Address:
Medical Reform Group
Box 40074
Toronto, ON, M6B 4K4

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 black 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 Alterna Savings and 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 (print)

Account holder's signature

Date

PANZI HOSPITAL CAMPAIGN UPDATE

Cathy Nangini

This summer marks the successful completion of the initial goals of the Panzi Hospital Campaign, initiated by S.A.F.E.R. (Social Aid For the Elimination of Rape) to address the wholesale violation of human rights against countless women and girls in DR Congo.

A shipment of nearly two thousand specialized wound care sutures, enough for one year of gynaecological surgeries for sexual violence survivors, were delivered to the Panzi Hospital (Bukavu, South Kivu) in June by the Canadian Embassy in Kinshasa.

Plans to scale up our initiative are underway, as we begin to organize a central database among hospitals across southern Ontario eager to donate unneeded medical instruments and basic supplies such as sterilization equipment, bed sheets, bed pads and operating theatre fixtures. Collabora-

tion with the CRN, a Norwegian NGO operating an ambitious program at the Panzi Hospital to build a new wing and operate a training program for surgeons, will allow us to access their extensive transportation network across Africa as a reliable means of making larger shipments.

Please check with your hospital or clinic for useable supplies that

could contribute to our supply list (see panel below).

As S.A.F.E.R. continues to grow in support and impact, we are ready to plan a research program for the second branch of our two-pronged approach: namely, we wish to visit the Panzi Hospital in the new year to document vital patient statis-

(continued on page 19)

PANZI HOSPITAL WISH LIST

- | | |
|---|--------------------------------------|
| ◆ Kidney Dishes | ◆ Uterus catheters (No. 4 and No. 5) |
| ◆ Hygiene items (e.g. absorbent pads to protect bed mattresses) | ◆ Towel clamps |
| ◆ Needle holders (20 cm. long) | ◆ Gauze, bandages, etc. |
| | ◆ Lab coats, latex gloves |
| | ◆ Bed Sheets, towels, etc. |

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*Please visit and comment on our web-site at <http://www.hwcn.org/link/mrg>
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