
Medical Reform

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CANWEST SET TO CHALLENGE BAN ON DTCA

Alicia Priest

CanWest Global Communication's bid to overturn Ottawa's ban on direct-to-consumer advertising (DTCA) of prescription drugs will face a stiff challenge after a court ruling has allowed a coalition of Canadian health and consumer groups and unions to intervene.

The Nov. 5th decision by the Ontario Superior Court means that CanWest will not only have to oppose Health Canada, which currently forbids public advertising of prescription drugs, but advocacy groups who fear that such advertising will lead to unsafe drug use and increased public health care costs. The case is scheduled to be heard in January or February, and will likely end up in the Supreme Court of Canada.

It is estimated that the annual Canadian drug advertising market is worth about half a billion dollars. The court decision means the coalition will be allowed to introduce evidence against lifting of DTCA and to cross-examine witnesses. Coalition members include the Women and Health Protection, Canadian Health Coalition, Medical Reform Group of Ontario, Canadian Federation of Nurses Unions, Canadian Energy and Paperworkers Union, Canadian Union of Public Employees, Drug Safety Canada and Society of Diabetic Rights.

"It's an important precedent in terms of an ad hoc coalition of groups applying for standing like this," said the group's lawyer Stephen Shrybman shortly after the November ruling.

Last December CanWest, which owns 11 of Canada's major daily newspapers including the *National Post*, a major television channel and other media outlets, launched a legal challenge to the federal law outlawing American-style prescription drug advertising, claiming that the regulation discriminates against its business interests. Betsy Chaly, CanWest director of corporate communications, said the basis of the claim is that

Health Canada regulations are contradictory to the Charter of Rights and Freedoms.

"In a nutshell really — because it's long and complicated — is that it's against freedom of expression," Chaly said. "From our perspective it's something that needs to be addressed especially with Canadians viewing television and journals, etcetera, coming from the [United] States that do allow DTCA. It's just the environment — it's time to look at this."

Coalition members, however, maintain that allowing DTCA would harm both the physical and fiscal health of Canadians. Citing the report of a senior FDA official who estimated that 35 000 to 45 000 Americans died from heart attacks due to the heavily-advertised and now withdrawn arthritic pain drug rofecoxib (Vioxx), they argue that the pharmaceutical industry is the last place to turn for reliable, unbiased and comprehensive information on medications (*Lancet* 2005; 365 [9458]: 475-481).

"Loosening the rules in any way will not be good for public health," says Women and Health Protection (WHP) Coordinator Anne Rochon Ford. "We feel there is a particular case to be made for the added impact on women, because women

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Please visit our website at: <http://www.hwcb.org/link/mrg>

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Contact us at:
Medical Reform
Box 40074, RPO Marlee
Toronto, Ontario M6B 4K4.
Telephone: (416) 787-5246
Fax: (416) 352-1454
E-mail: medicalreform@sympatico.ca

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.

CANWEST SET TO CHALLENGE BAN ON DTCA (continued)

are prescribed more drugs and because women are often the targets of the advertising, there are specific campaigns directed very pointedly at girls and young women for certain drugs.” The WHP group is urging people to tell their elected representatives, including the federal health minister, that they oppose legalizing DTCA.

The coalition’s economic concern focuses on research showing that DTCA results in increased drug consumption particularly of newer, more expensive drugs (*CMAJ* 2003; 169[5]: 405-12). That outcome, they say, will drive up costs of health benefit plans and threatens the sustainability of publicly funded health care.

“DTCA will basically destroy Medicare,” says Mike McBane of the Canadian Health Coalition. “Drugs are the biggest threat to public health insurance programs in Canada — costs are completely out of control. Prescribing practices are out of control and they will get worse by a factor of 10 if they start saturation drug ads.” According to the Canadian Institute for Health Information, drugs are the fastest growing category of health care spending, with total expenditures estimated to have reached almost \$25 billion in 2005, an increase of 11% over the previous year.

Barbara Mintzes, researcher with the University of British Columbia’s Centre for Health Services and Policy Research, says she is stunned at the timing of the CanWest challenge.

“The key surprising aspect of this case is that it comes at this point in time, after the Vioxx disaster and also after the US industry association has brought in self-regulatory guidelines to limit its own advertising practices,” Mintzes stated in an e-interview from Amsterdam. “Secondly, the Institute

of Medicine report on drug safety in the US drew a strong link between safety concerns and DTCA. They recommended a moratorium on any advertising to the public of drugs within their first two years on the market, within a US context in which a total ban was unlikely.”

DTCA is a live issue elsewhere as well. In Europe, a proposal to weaken the ban on advertising prescription-only medicines was overwhelmingly rejected by the European Parliament 2 years ago. The European Commission recently stated that it regrets that decision and called for a reform of the European pharmaceutical legislation.

However, in New Zealand — the only country other than the US that currently allows DTCA — the government is expected to ban DTCA after several reviews recommended rejecting it and the fact that many doctors in New Zealand oppose DTCA (*Br J Gen Pract* 2003; April: 342-5). ♦

Reprinted from CMAJ, January 2, 2007 with permission of the author, Alicia Priest, Victoria

SOME CONSIDERATIONS FOR TODAY'S PROGRESSIVE PHYSICIANS

Hareesh Kirpalani

These are personal views prompted by a recent debate in the MRG on 'expensive therapies' and who funds them. The bottom line of that debate was that therapies of proven effectiveness should be provided at no cost bar the cost of taxation.

In my view, this whole issue is inextricably bound up with one myth and one pointlessly stark contrast. The myth is that of 'One society' – ignoring the obvious reality of a class divided society. The unneeded stark contrast is 'prevention or cure', coming from the ancient public health ethos that propounds an 'ounce of prevention is better than a cure'.

This adage is no doubt largely correct. But it is trumpeted as a truism used by a capitalist ruling class to present a 'rationale' to cut or deny curative health services. This was done under Thatcher to the National Health Services in the UK, and its replacement with a private system has been well chronicled by Prof Pollock (Reviewed in: "NHS PLC: The Privatisation of Our Health Care": Re-

view of Radical Political Economics. 2006; 38: 484-487). Surely we need both prevention and cure?

The Background – (a) Modern Day Determinants of Ill Health

Societies evolve. If this is true, it is very likely that the diseases of the society reflect the society itself. It is hardly surprising that the burden of illness and disease should change as society changes.

It remains appropriate for health policy advocates to talk about 'the determinants of health' but what are the 'determinants of health' in a modern day society? Are they only water supply, clean housing, adequate-good nutrition?

What do we have to say on severe cardiovascular disease and hypertension? What do we have to say on pollution or environmental carcinogens? What explains the epidemic rise in cancer rates for instance? What underlies an apparent rise in suicide in young alienated teenagers? Are these related to the development of capitalist profits or not?

This maybe a crude formulation, but how else would one put it? It is apparent that neither cardiovascular disease nor cancer fit easily, the older infectious aetiologies. But they are societally determined. A special role must be reserved for that special determinant of health - poverty.

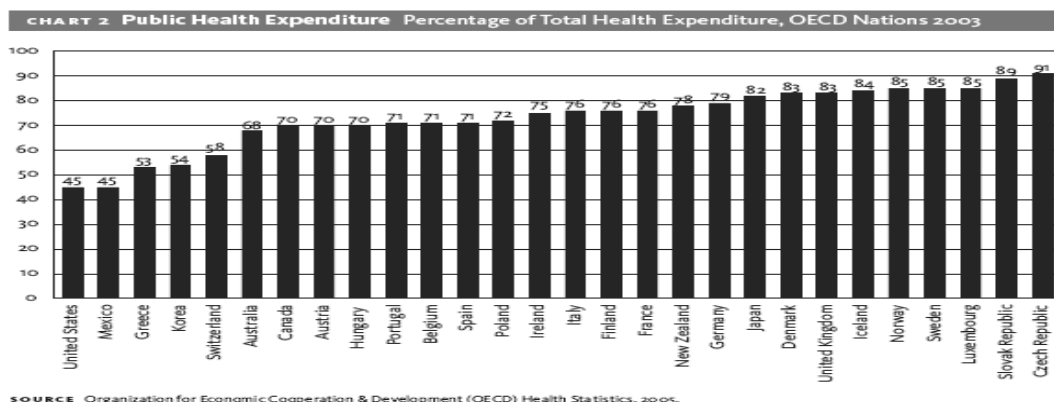
This will be discussed shortly, in context to its partner - wealth. If it is true that societal origins are in part responsible for the explosion of various 'modern day epidemics' – what does this imply about societal responsibility? And who actually exercises that 'societal responsibility'? Whose guardian is the MRG?

(b) The Nature of Capitalist Society and the myth of 'One society'?

'Society' has been liberally invoked above. But, the term implies a singular homogeneity, and often fosters illusions. For there is not 'one society' – there is the workers society and there is the capitalists' society. Some things have not changed fun-

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Figure 1. Public Health Expenditure as a percentage of Total Health Expenditure, OECD Nations, 2003



SOME CONSIDERATIONS FOR TODAY'S PROGRESSIVE PHYSICIANS (continued)

damentally. While definitions may be open to debate, the reality of this division is not.

For example the Whitehall study indicated that individuals in the higher echelons experience less CVS risk than do those in the lower echelons (reviewed at: http://en.wikipedia.org/wiki/Whitehall_Study#Whitehall_I; Marmot M. Social determinants of health inequalities'; Lancet. 2005 Mar 19-25;365(9464):1099-104).

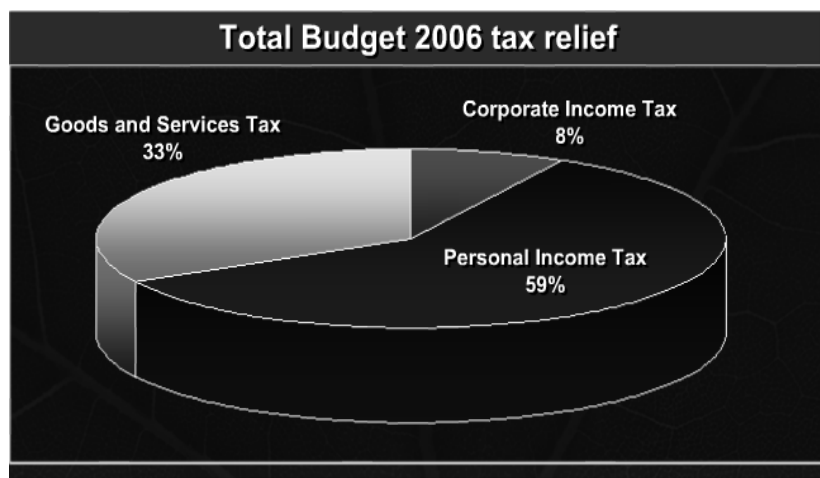
True the people at the lower rungs of the Whitehall study, may not immediately remind one of the 'proletariat' of the 1880's. I do not propose to discuss this here, and will simply argue that the essential characteristic of 'workers' is their lack of ownership of the means of production – meaning they have to work for a living.

Even if that loose definition is unsatisfactory, surely the following should be acceptable: 'What is of interest to the capitalist is not the same as of what is of interest to the worker'. The workers wish to achieve a reasonable standard of life: including education, access to health care services and some measure of life security. The capitalists wish to maximize profit and to minimize 'payouts' to the worker. Payouts here include access to expensive health care.

(c) Capitalists and Health

Capitalists are not necessarily averse to spending liberally on health care where it was essential to their own well-being. To maintain a healthy war machine during the Boer War, the ruling class made steps towards public health. The ruling class

Figure 2. Federal Budget 2006



recognized that averting diseases of potential infective epidemic nature was important. In England it charged Owen Chadwick to create one of the first national sanitation systems.

However capitalists are less inclined to spend liberally on diseases not obviously linked to an immediate threat to them from the 'great unwashed'. Moreover, they are reluctant to curb profit-making in areas linked to modern diseases, as shown by two major modern epidemic diseases: cancers and cardiovascular heart and stroke disease.

Moreover, both are intimately related to major profitable sectors of the economy. These are firstly the foods industry (marketing cheap but likely dangerous food-stuffs); secondly those industrial concerns linked to the plastics and chemical industry (which are uninterested in the potentially carcinogenic effects of their unchecked growth). Finally there is the pharmaceutical industry that has a vested interest in marketing expensive drugs in this area. One developing and profitable area is private health care.

Is it true that Government is impoverished? I suppose no one really says this, but in health economic speak, there are echoing images of a rag-wrapped, penurious government (see 'Putting a Price on life'; Drummond M and Marshall D; Globe and Mail December 8th 2006; p.A25). Further, how closely does government reflect the interests of 'workers society'? Firstly Canada is not anywhere near the highest spender on health care. This is demonstrated in Figure 1, page 3, using OECD figures from 2005. I do not argue about how much better outcomes might be – I am simply addressing the issue of 'too little money to pay for expensive drugs'.

Second: Governmental revenue collection (its income) is hardly especially hitting the very well off. Figure 2 is drawn from a government web-site [<http://www.fin.gc.ca/budget06/transcrp/slidee.htm>] and shows that a minuscule portion of tax comes from the fat cats.

The same web-site also projects an even greater fall in cor-

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SOME CONSIDERATIONS FOR TODAY'S PROGRESSIVE PHYSICIANS (continued)

porate taxes from 36 to 32 per cent between 2006 and 2010.

This now should be related back, to the determinant of health that was left aside under (a) above. For the poverty of some – is directly linked to the wealth of others. This togetherness (some would say dialectical relationship) is usually ignored in academic treatises on poverty as a determinant of health.

(d) How Transparent Are Decisions on Budget and Financing of 'Society' Today?

Undoubtedly our society has a democratic character. But, the 'choice' of the population to elect representatives is, I would contend, largely restricted to a support of the status quo. Even if you disagree with this viewpoint, ask 'how much real information is available to the population?' Or 'What do we really know about the distribution of the budget?'

Or 'What do we even know about the Budget's overall 'plus' sign or 'negative' sign?' There are very big games going on behind locked doors. As noted, the Ministry of Finance website makes statements about the budget, not whether a 'surplus' might or might not exist. Who knows the real state of affairs? These are shell games of convenience to the representatives of the ruling class. To base arguments on whether or not funding for drugs are to be made on them, is foolish to say the least.

Global budget totals are bad enough to fathom, but what about how the apportioning of the total to sub-components takes place?

What drives the apportioning of monies for troops in Afghanistan as opposed to the health service? And do restrictions in the health care sec-

tor really increase monies for women's shelters? Who makes those decisions? How are they made? Did you know the figures of Canadian public funding for Radarsat programs for the USA? [<http://policyalternatives.ca/MonitorIssues/2006/06/MonitorIssue1389/index.cfm?pa=DDC3F905>] All this at a time when the federal Finance minister Flaherty projects "unexpectedly large surpluses over the next years" (Editorial November Globe and Mail p.24).

(e) What Are the Consequences of Restricting 'Expensive' Therapies on the 'Public purse'?

If public funding for proven therapies does not occur, it is clear that this will inevitably lead to a two tier health care system. This is already happening: "For the first time, cancer patients across Canada will be offered what the public health care system has been unable to deliver: iv drugs not covered by medicare for those who want to prolong their lives or fend off a recurrence – for a price.

In what could be likened to one-stop shopping, patients can buy cancer medicine not paid for by their provincial governments... Medication will be administered.. in one of 18 infusion clinics across Canada. Three key players are providing the service: Roche Canada a drug company that holds the license for five cancer products; McKesson Canada which is administering the program; and Bayshore Infusion Clinics Inc; which provides clinical staff and medical equipment" (Globe & Mail; December 8th 2006; p. A1; A14).

If the MRG supports this, this will result in the reneging of some

key elements of the MRG Founding Statements, and should give pause to those members who joined on the basis of those founding statements.

When cross country comparisons of health care expenditure are made, the volume of public spending in Canada is usually stressed. It is of interest then that currently almost 3 per cent of a total of 9 per cent health care spending – is from a private source [<http://policyalternatives.ca/MonitorIssues/2006/06/MonitorIssue1389/index.cfm?pa=DDC3F905>]. What hope has the MRG of convincing either professional to join them, or to obtain support from the population when they deny obvious long waiting times as compared to (even) the UK (Globe and Mail November 24th 2006; p.A1; A16).

(f) What Possible Alternatives Are There to 'Restricting' Public Payment?

It is interesting to compare the current discussion, with how the discussion on anti-retroviral therapy proceeded. This of course is a transmissible infectious disease. On the whole it would seem to me that progressives were pretty clear that this type of therapy, potentially expensive – should be made available. It is striking to me, how this is patently not so argued for anti-cancer drugs.

Previously the MRG reviewed options for effective but costly therapies. These included insistence on obtaining greater democracy in community control of hospital boards, to explicit societal trade-offs of helicopters versus drugs. Perhaps another set of areas that need atten-

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SOME CONSIDERATIONS FOR TODAY'S PROGRESSIVE PHYSICIANS (cont'd)

tion from the MRG include: Caps on drug company profits; insistence on adequate arms length research for new therapies with clinically relevant outcomes; insistence on adequate environmental research on aspects of oncogenesis; more adequate curbs on the foods industry etc.

These require political will to stand against profiteering. Given the propositions that I offer under (b) and (c) above, it is unsurprising that I am highly doubtful that the Conservative or Liberal government would ever take such positions. In my opinion, when push comes to shove, I doubt the NDP would. But in a sense, that is not the MRG's problem. The MRG's problem is how ethically to form a position on this question. ♦

ONTARIO'S FINANCES IN BETTER SHAPE THAN LIBERALS LET ON, SAYS ONTARIO ALTERNATIVE BUDGET

Ontario's finances are in much better shape than Finance Minister Greg Sorbara claims, says an Ontario Alternative Budget (OAB) Technical Paper released today by the Canadian Centre for Policy Alternatives.

According to the report, authored by OAB Co-chair and CCPA Research Associate Hugh Mackenzie, it is well within the government's capacity to balance its budget in each of the next three years—contrary to the government's 2006 Fall Update, which projected deficits through 2008-9.

The report points out that this year's deficit is entirely attributable to reserves and contingency funds that, half way through the fiscal year, have not yet been spent. Contingencies and reserves included in the deficit calculation total \$2.5 billion, well in excess of the forecast \$1.9 billion deficit.

"Without reserves and contingency allocations, the Budget is in surplus in each of the three forecast years," Mackenzie explains. "In addition, the government has continued its practice of underestimating revenue and overestimating expenditures and debt service costs in its budget forecasts."

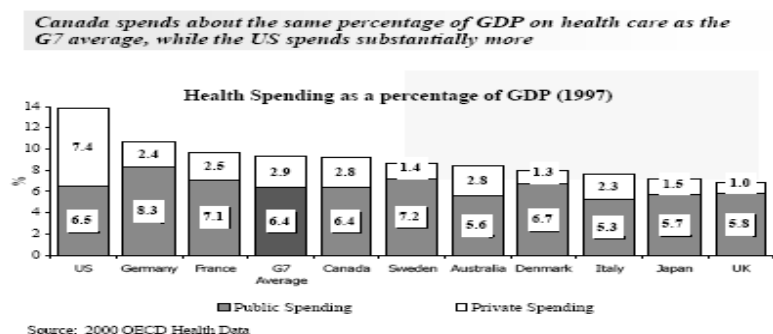
In both of the Budget years for which the Liberal government was fully responsible and for which final numbers are in, the final Budget balance was substantially better than the position forecast at budget time.

Mackenzie suggests the government is trying to keep the deficit story alive for the next 10 months in order to generate a "surprise" balanced Budget on the eve of the 2007 election campaign.

While Mackenzie asserts that a surplus is likely in each of the next three years, those surpluses will not be substantial. "They are unlikely to approach the \$2.4 billion cost of repealing the Health Premium, for example," he says. ♦

The Ontario office of the Canadian Centre for Policy Alternatives responded November 12th, 2006 to the fall Economic Update released by Ontario Finance Minister Sorbara, as the Ontario Alternative Budget Working Group began its deliberations on the 2007 Alternative Budget. For more information, see www.policyalternatives.ca

Figure 3. G-7 Health Spending as a percentage of GDP, 1997.



[Source: Strategic Policy and Research, Intergovernmental Affairs 2001; <http://www.pnrec.org/2001papers/DaigneaultLajoie.pdf>]

ONTARIO MUST TREAT HEALTH CENTRE STAFF FAIRLY

Miriam Garfinkle and Sharon Gazeley

Most Ontarians are aware that our health-care system eats up an enormous percentage of the provincial budget. What fewer people know about is perhaps one of the best-kept secrets of Ontario's health-care system: the network of 54 Community Health Centres (CHCs) spread out across the province.

For more than 30 years, CHCs have been delivering health care and social services to diverse communities in the province.

Funded by the ministry of health, CHCs provide a comprehensive model of multidisciplinary primary-care services intended to serve both urban and rural communities.

CHCs are managed by community boards of directors who are made up of people from the local community including those who use the health centres' services.

The budgets of every CHC in Ontario added together comprise a mere 0.0056 per cent of Ontario's health-care budget. Yet, despite providing a shining example of a primary health-care model that really works, recent actions by the health ministry threaten to undermine the ability of CHCs to provide comprehensive health care.

Historically, CHCs have been set up to serve people more susceptible to health problems than the general population, such as refugees, new immigrants, seniors and people with low incomes, including the homeless and those living in rural poverty.

Many of our patients have no money left for food, let alone healthy food, after they pay their rent. Many live in crowded shelters or outdoors without shelter. Although it is challenging to provide good care to people who

lack many of the social determinants of health, CHCs have shown that it is possible to do just that with a solid team approach.

We have palliative patients attempting to die with dignity in apartments infested with thousands of bedbugs. Because they cannot afford the services of pest control companies, essential homemaking and home health-care services pull out.

Community Health Centres provide shining examples of primary health care that really works.

We often look after pregnant refugees who come to us late in their third trimester, having received no prenatal care — in which case we must cram nine months of prenatal care into a few short weeks. We care for many newcomers who have experienced war and torture and who come to us with profound symptoms of depression and post-traumatic stress. A larger than average number of children in our community have speech and language delays and developmental problems that require prompt and decisive interventions.

Our patients have complex health and social problems. While we can prescribe medication to lower their high blood pressure or help them manage their diabetes, who is going to obtain prescription drug coverage for them? Who is going to help them obtain a health card so they can see a specialist?

Who is going to help them stave off ever-imminent evictions? Who will intervene to correct mindless bureaucratic errors that result in lost income cheques? Who will help those with disabling anxiety learn coping strategies to function in the world?

Who will run prenatal classes, teach parenting skills, grow community

gardens in impoverished communities and develop innovative outreach programs so that the most vulnerable are not excluded from the health-care system?

The answer is, the amazing multidisciplinary teams we work with every day: nurses, social workers, community workers, dietitians, ethno cultural outreach workers and administrative staff who maintain the flow of patient care and programs.

Without them, we cannot provide good care to our patients. Without them, our patients' health is seriously at risk. Without them the future costs to the health-care system will be greater than ever.

While physicians have powerful professional organizations to fight for decent salaries, our colleagues unfortunately do not.

Currently, CHC workers are negotiating for salary increases with the ministry of health, without much success. For all the reasons outlined above, we would like to see the government deal fairly with these highly skilled health and social service staff, who work with some of the most challenging patients in the province.

If no just settlement is reached, the government will ultimately jeopardize our ability to properly care for patients. ♦

Published as an op-ed in the Toronto Star, Tuesday, January 16, 2007; Miriam Garfinkle and Sharon Gazeley are both family physicians working in a downtown Toronto Community Health Centre; if you have experience/interest/energy to share on this important file, please contact medicalreform@sympatico.ca

ONTARIO HEALTH COALITION RELEASES ANALYSIS OF BILL 140--ONTARIO LONG TERM CARE ACT

[Assembled by Janet Maher from Ontario Health Coalition updates.]

The new Long Term Care Act recently passed second reading and will be hearing public briefs until January 24th, 2007.

Members are encouraged to take every opportunity to make local MPPs aware of their concerns. For a full list of Ontario MPPs, and for a copy of the full coalition brief presented January 16th, 2007, see: www.web.net/~ohc.

You will find the OHC comparison of the Bill with key demands below. Some key points in addition to those outlined below:

1. Currently there are 49,700 nursing home beds of which about 10,200 are non profit. Currently there are 24,700 homes for the aged and rest

homes beds of which 16,700 are public (municipal) and the rest are non profit (8,000). (Total figures: 39,500 for profit, 18,200 non-profit, 16,700 public.)

These beds are governed by three Acts: The Nursing Homes Act, The Charitable Institutions Act, and The Homes for the Aged and Rest Homes Act. Under the Harris government, the Red Tape Commission recommended that the three existing Acts be rolled into one. Since then, there have been reports that the Ministry of Health and Long Term Care has been drafting a new Act. Bill 140 - An Act Respecting Long Term Care Homes is the new Long Term Care Act which repeals the three existing

acts and replaces them.

2. There is no obligation for the government to provide for and fund access to long term care. In fact, the fundamental principle in the previous Acts stated that homes should be run to adequately meet the needs of the residents. This is now removed. In all the sections of the act that deal with admissions and standards there is no obligation of the Ministry to provide access to care and adequately meet the care needs of residents.

3. Many of the standards and other provisions of the Act will be set out in regulations. But there is no requirement for the government to consult on the regulations. We are advocating for a consultation process. ♦

ONTARIO HEALTH COALITION KEY ISSUES--NOVEMBER 25, 2006

Adequate funding must be provided for ongoing supportive home and community care to offer seniors, persons with disabilities and those with chronic illnesses the opportunity to live in the community as long as possible.

NOT IN THE ACT

1) A province-wide minimum staffing standard that ensures sufficient hands-on staff to provide a minimum of 3.5 hours per day of nursing and personal care per day per resident. This is to reach the goal of prevention of risk, it is not an optimum. Increases in staffing should be shared proportionately among all members of the health care team. The government must fund and set standards for specialty units or facilities for persons with cognitive impairment who have been assessed as potentially aggressive, and staff them with sufficient numbers of appropriately trained workers.

NOT IN THE ACT: THERE IS A POSSIBILITY IT CAN BE INCLUDED IN A REGULATION PERTAINING TO STANDARDS BUT THE GOVERNMENT HAS NOT YET AGREED TO THIS.

2) A provincial funding model that is based on a uniform assessment tool across the province to ensure that there are uniform provincial standards and funding assessment tools across all LHINs. The funding model must provide adequate funding for the required staffing ratio set out in #1 and strong accountability as to how that money is spent.

NOT IN THE ACT: THE FUNDING AND ASSESSMENT TOOLS ARE LEFT TO REGULATION AND LICENSE AGREEMENTS AND LHINS SERVICE AGREEMENTS.

3) The continuance of the new completely random surprise inspection regime with an adequate number of inspectors to respond to complaints within a reasonable amount of time. Any assessment process must include talking with representatives from residents' and family councils where they exist and speaking to nursing and personal care staff. ANNUAL INSPECTIONS THAT ARE UNANNOUNCED ARE IN THE ACT. OTHER INSPECTIONS MAY BE PRECEDED BY NOTICE TO THE FACILITY UNDER THE REGULATIONS. HOWEVER, THE REGULATIONS MAY EXEMPT SOME HOMES FROM ANNUAL INSPECTIONS.

ONTARIO HEALTH COALITION RELEASES ANALYSIS OF BILL 140-- THE ONTARIO LONG TERM CARE ACT (continued)

4) A ratio of 60% of facility beds for non-preferred accommodation and 40% for preferred accommodation should be reinstated. No increase in out-of-pocket fees for beds beyond inflation.

NOT IN THE ACT: THIS HAS BEEN LEFT TO THE REGULATIONS.

5) All long term care facility beds receive public funding. The legislation must include strong message of support for public and non-profit delivery of care. All new capacity should be built in public and non-profit homes. Operators that transfer their licenses must transfer them to public or non-profit ownership only.

NOT IN THE ACT: THE ACT IS IN OPPOSITION TO THIS. TRANSFERS FROM NON-PROFITS TO FOR-PROFITS ARE ALLOWED AS SPECIFIED IN REGULATIONS. MUNICIPALITIES IN THE NORTH ARE NO LONGER REQUIRED TO HAVE HOMES. THIS ALLOWS THE BALANCE OF HOMES TO SHIFT FURTHER TO FOR-PROFITS.

6) Family councils should be recognized in the legislation with official recognition of their right to advocate. Families must be guaranteed access to the information required to hold facilities accountable. Complaints by family members must trigger an automatic inspection within two weeks of receipt of the complaint. In the case of abuse, the inspection must be immediate. Inspectors should be mandated to meet with family and resident councils where they exist. The Ministry should continue to provide funding and support to establish and continue family councils through the office of the elder care ombudsperson. There must be whistle-blower protection for residents, families and staff that speak out about poor practices in the homes.

FAMILY AND RESIDENTS COUNCILS ARE RECOGNIZED AND HAVE A RIGHT TO RAISE CONCERNS OR COMPLAINTS. NO ROLE IN APPEALS OR INSPECTIONS. COMPLAINTS TRIGGER INSPECTIONS IN PARTICULAR CIRCUMSTANCES. IMMEDIATE INSPECTION IN CASES OF ABUSE IS IN THE ACT. NO FUNDING FOR RESIDENTS AND FAMILY COUNCILS IN THE ACT. NO OMBUDSPERSON. THERE IS WHISTLE-BLOWER PROTECTION IN THE ACT.

7) There must be clear and enforced guidelines in the legislation limiting the use of physical, chemical and environmental restraints on residents. Restraints should only be used for the purpose of preventing harm. There must be a clear decision-making process, notification of families, and restraints-as-last-resort policies.

THIS IS IN THE ACT. THERE IS, HOWEVER, SOME CONCERN THAT CHEMICAL RESTRAINTS ARE NOT TREATED THE SAME AS PHYSICAL RESTRAINTS AND ARE NOT RECOGNIZED AS RESTRAINTS IF THEY ARE SET OUT IN THE RESIDENT'S CARE PLAN.

8) Program standards must be reviewed and improved and enforced through the inspection regime set out in #3. More attention must be paid to homes that are non-compliant and strong and effective sanctions must be imposed on homes that are consistently non-compliant with significant care standards including non-renewal of the license to operate.

THERE ARE POTENTIAL SANCTIONS FOR NON-COMPLIANT HOMES. THERE IS NO OBLIGATION FOR THE MINISTRY TO PURSUE SANCTIONS FOR PERSISTENTLY NON-COMPLIANT HOMES.

9) The training opportunities for front-line staff, administrators, and Compliance Advisors must be improved to ensure consistency and an understanding of how to provide residents and staff a safe, secure and compassionate environment.

THERE ARE TRAINING PROVISIONS IN THE ACT, HOWEVER, THEY NEED TO BE IMPROVED TO COVER EQUITY ISSUES AND PSYCOGERIATRIC ISSUES, AMONG OTHERS.

10) Consultation on adequate regulation of retirement homes should be instituted.

NOT IN THE ACT. ♦

MEDICAL REFORM GROUP LAUDS ALBERTA HEALTH CARE TURNAROUND

The latest developments in Alberta show that even right-wing governments can become sensible, and heed the evidence about the best ways of delivering health care,” Medical Reform group spokesperson Ahmed Bayoumi said today.

The Alberta government cannot cure the growing costs that ail the health-care system by allowing more private-sector treatment, and the Tories went “astray” by trying to do so, new Alberta Health Minister Dave Hancock said Monday.

Hancock effectively killed notions the new Ed Stelmach government would wade into the divisive and controversial “third way” reforms former premier Ralph Klein tried to push through before being

pushed by his Conservatives into retirement last year.

“I think that’s where perhaps we’ve gone astray in the process,” Hancock told reporters. “All Albertans should have access to quality care on a timely basis without regard to the bills they pay. It has to start and finish there.”

“Whether his reasons are political expediency or a realization that publicly funded health care is not only more equitable, but more efficient doesn’t really matter,” said another MRG spokesperson, Dr. Gordon Guyatt. “This is good news for Albertans – and the change of heart is good news for all Canadians.”

The realization that universal coverage is necessary in a civilized

society is even beginning to make inroads south of the border.

“It’s only sensible that when even American Republicans like California Governor Arnold Schwarzenegger are moving toward universal care, Canadians should avoid any backsliding,” said Dr. Bayoumi.

“There is still the stealthy privatization of for-profit clinics offering queue-jumping for the rich to deal with,” said Dr. Bayoumi. “But the Alberta experience suggests that politicians are waking up to the fact that publicly funded health care delivered by not-for-profit providers is best for Canada.” ♦

*Released by the Medical Reform Group
January 11, 2007.*

MEDICAL REFORM GROUP CONGRATULATES HARPER ON DROPPING WAIT TIMES GUARANTEE

The MRG of Ontario is congratulating Stephen Harper on effectively dropping his wait time guarantee policy, a cornerstone of his 2004 election victory.

“While the Conservative government claims the guarantee is alive, their behaviour and that of the provincial governments shows it is dead,” said MRG spokesperson Dr. Gordon Guyatt. “And that is a good thing.” Wait time guarantees focus excessive attention on those nearing the guarantee deadline. Doctors start to see patients approaching the deadline before they see new patients with more pressing needs.

Thus, wait time guarantees result in a set of perverse incentives.

Patients start getting on lists early, even if their problems are trivial. Specialists make many quick short first appointments to ensure patients get off the wait list. Unfortunately, the process of actually sorting the problem out may lengthen interminably.

Norway, Sweden, and Denmark have all tried and abandoned guarantees. Where they persist, they create an unhealthy tension between treating according to need, and treating according to time on the list.

“Now, Harper should come clean and admit that wait time guarantees are a failed strategy,” Guyatt said.

Harper’s admission would only be politically feasible if accompanied

by a serious plan to deal with wait times in a productive way.

“An announcement accompanied by targeted funding for developing a national information technology system for reduce wait times would be real progress. Serious moves toward national Pharmacare and national home care programs would reduce wait times would mean real improvement in Canadian health care,” Guyatt concluded. ♦

*Released by the Medical Reform Group
January 10, 2007*

TWO-TIER HEALTH CLINIC OPENING IN KINGSTON TODAY CONTRAVENES LAW: ONTARIO HEALTH COALITION CALLS ON MINISTRY TO TAKE ACTION

The Ontario Health Coalition has requested that the Minister of Health take action to stop a two-tier clinic from siphoning doctors and nurses out of the public health system to serve wealthy queue-jumpers with unnecessary health services. The clinic is opening its doors in Kingston today.

The clinic, called “Health For Life” charges an initial year fee of \$2,500 and \$2,000 each subsequent year for enhanced health services. Marketing for such “boutique” medicine clinics is generally targeted to those who are known as the “wealthy well” or the “worried wealthy”.

“In our view, even at this stage, the company’s advertising appears to violate Ontario’s Commitment to the Future of Medicare Act by offering to confer preferential access to insured health care services,” said Ross Sutherland, RN, Kingston Health Coalition co chair. “In addition, the Canada Health Act requires the province to provide equal access to medically necessary health care. If violations are found the clinic risks fines under Ontario law and the province risks cuts to its transfers from the federal government under the Canada Health Act. Any physicians that sell two-tier services risk fines and discipline for professional misconduct.”

“We believe that this situation is unethical, unlawful and destructive, and we are asking the McGuinty government to act immediately to stop it,” he added.

“We are deeply concerned about the attempt to create Americanized two-tier health services and undermine the achievements of universal Medicare,”

added Natalie Mehra. “In its advertising, the company is charging a fee for preferential access to physician and related services, co-mingling unnecessary services with those that are insured by OHIP. The Health Coalition raised the issue with the Ministry this afternoon. We are optimistic that the government will intervene to protect the principle of equal access to health services for all Canadians, regardless of income.”

Background:

1) The offer to accept payment for conferring preferential access, the act of paying or providing preferred access for those who pay, or failure to report such activities contravenes the Commitment to the Future of Medicare Act and are subject to a fine that the Ministry can levy.

2) The provision of intake, medical history and medical records are covered by OHIP and cannot be subject to fees under the Commitment to the Future of Medicare Act.

3) Clinics that provide preferred access to insured services as a result of paying fees are in violation of the Canada Health Act that states that the health care insurance plan of a province “must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons...” The province is expected to enforce the CHA and can have its transfer payments from the federal government reduced for violations.

4) Clinics cannot refuse patients who refuse to pay block fees and cannot provide preferred access for those who do pay the fees. ♦

Released December 12, 2006 by the Ontario Health Coalition

REPORT CARD ON ONTARIO BILL 8

Janet Maher

Shortly after their election in the fall of 2003, the McGuinty government sprang to the defence of Medicare with Bill 8, the Commitment to the Future of Medicare Act, which purported to slow the drift to delist and otherwise limit access to publicly funded health services. The Medical Reform Group intervened assertively, seeking specific regulation to hold government and service providers accountable.

An increasing number of reports of ‘private clinics’ or stories of expedited access to health services is beginning to concern many of our members and allies, as demonstrated, for example in some of the stories in this issue.

Voters in Ontario will have a chance to make their views known when Ontario has its first fixed date election on Monday, October 4, 2007. The MRG is making plans to prepare a report card on the effectiveness of Bill 8 and welcomes information that will help us evaluate the government’s progress on this important issue. ♦

MEDCAN RECRUITS PHYSICIANS FOR OPTIMUM CARE

Several members have forwarded solicitations like the following, as professional recruiters invite physicians to change their mode of practice.

Re: Medcan

Because of their expansion plans, Medcan have asked us at The Caldwell Partners International once again to assist them in finding Family Physicians to join the Medcan team.

Medcan is expanding three ways:

- ☐ Medcan's patient group is growing exponentially;
- ☐ Medcan will be opening an office in Mississauga/Oakville in 2007;
- ☐ Medcan has formed an official partnership with Johns Hopkins Medicine International.

At Medcan, the focus is two-fold: helping patients to prevent illness and disease through proactive management of their health, and identifying health risks before symptoms occur. Using the best available testing, screening processes and medical assessments, Medcan assists individuals, including the key personnel of Canada's leading corporations, in taking control of their health.

Imagine:

- > Spending up to 45 minutes with each patient;
- > Having regular, routine office hours with no night work;
- > Customizing your work week from one-half day to one, two, three, four or five days;
- > Having first-class office and equipment provided;
- > Being pro-actively supported by a multi-disciplinary team of totally dedicated health professionals;
- > Collaborating with Johns Hopkins Medicine International.

For your information, we have included the ad copy that we are running, and we appreciate the time you are taking to read this. ♦

ONTARIO HEALTH COALITION HONOURS DEVEREAUX

The Medical Reform Group has collaborated for several years with the Ontario Health Coalition, particularly in advocating for high quality publicly-funded health care in Ontario. In September, 2006, Steering Committee member Danielle Martin nominated Dr. P.J. Devereaux for a research award being offered for the first time to honour long-time seniors activist Ethel Meade on her retirement as co chair of the coalition.

The award was presented at the Ontario Health Coalition annual meeting, Saturday, October 14th. The text of Danielle's nomination follows:

Dr. P.J. Devereaux, has performed a series of systematic reviews comparing for-profit and non-profit health care. He and his team have found that care delivered in a variety of for-profit settings is not only lower quality (leading to higher death rates), but also more expensive.

These are the most rigorous studies on the subject and have been published in the leading medical journals. His findings have been widely cited by academics, policy-makers and the media.

Dr. Devereaux was even invited to give a special presentation about the implications of his research to the Hon. Roy Romanow while he was writing his 2002 Royal Commission report. Dr. Devereaux has also done a superb job of disseminating his research findings, by publishing several opinion pieces in newspapers, speaking on television and radio, and giving keynote addresses at many meetings. ♦

MEDCAN RECRUITS PHYSICIANS FOR OPTIMUM CARE (continued)

The Medcan Clinic is Growing

The Medcan Clinic is one of North America's leading providers of preventive medicine. Established in 1987, and headquartered in Toronto, Medcan offers an array of medical services including the four-hour Comprehensive Health Assessment. Medcan will be opening a second location in Oakville/Mississauga in 2007, and is actively looking for physicians, for both the downtown location and the new location.

Medcan partners with Johns Hopkins Medicine International

The Medcan Clinic will serve as a portal for Canadians who wish to seek medical care from Johns Hopkins. Clinical services from Johns Hopkins will also be integrated into the comprehensive wellness programs already offered by the Medcan Clinic to its clients. In addition to referral and clinical services, the partnership establishes areas of collaboration, including medical education, clinical observerships and medical research focused specifically on preventive health. Medcan's services are expanding, as are the number of clients using their sophisticated services. As a consequence...

Family Physicians are needed for Quality Care Practice

Medcan will provide you with an opportunity to practice with a multidisciplinary team of professional colleagues, comprehensive support staff, and state of the art medical equipment, in either a full-time or part-time role. The right physician for this organization will want to spend quality time with patients and be unfettered by the demands of administration, costs, and the clock. Physicians will also discover that their earning potential is enhanced and the regular hours of work are lifestyle-friendly. Medcan is seeking physicians with a CCFP (Family Medicine), or specialists in Internal Medicine, eligible for licensure in Ontario. If you have a reputation for excellent interpersonal skills and a strong service ethic, we would like to explore this career opportunity with you. Candidates from across Canada and the U.S. will be considered.

Please review our website at www.medcan.com for additional information.

If you, or a physician you know, would be interested in exploring this opportunity further, we would be pleased to book a time to connect by phone, if that would work best for you. ♦

BALANCING PRIORITIES: FALL MEMBERS MEETING

With the help of SC member Ahmed Bayoumi and his colleague Dr. Andreas Laupacis, MRG members had a chance Thursday, November 16th to consider the best approach to addressing the high cost of drugs in Ontario and in Canada.

Bayoumi shared his views on a range of issues and observations relating to his health services research, noting that there are likely few who would oppose the objective of sacrificing some allocation efficiency to gain equity. The more difficult question in

his view was determining how equity be defined, particularly in therapies where treatments were very costly and of marginal benefit. He offered comparisons to British process, recommending ultimately that MRG monitor developments over the next period.

Dr. Andreas Laupacis was, until recently, the chair of the Canadian Expert Drug Advisory Committee (CEDAC), charged with reviewing evidence to be used by provincial drug benefit plans in determining which drugs should be added to provincial drug formularies [and hence qualify

for public funding]. He summarized his experience as committee chair, suggesting that in advisory structures which combined 'expert' and 'citizen' participants, there appeared to be marginally more reluctance to approve for funding therapies at the margins of cost and effectiveness than with 'experts' alone. He also expressed some concern that issues of pricing were not within the mandate of the CEDAC.

Copies of Dr. Bayoumi's slide presentation are available on request from medicalreform@sympatico.ca. ♦

ENGAGING THE CANADIAN MEDICAL ASSOCIATION ON THE PUBLIC-PRIVATE INTERFACE

Excerpts of a letter written October 28th by Steering Committee member Dr. Norman Kalant to the new president shortly after he assumed office, on concerns about the CMA's apparent ambiguity on private health care. Dr. McMillan's office authorized publication of his reply of November 20th and has promised an update on the CMA position in time for our spring newsletter.

The Chaoulli decision required that we deal with the problem of waiting times, but the manner in which we approached the problem was our own doing, and in my opinion was ill-advised and illogical; our efforts have not contributed in any significant way to finding an equitable solution.

The main reasons for this opinion are as follows:

1. When a patient comes to us with a symptom or problem we attempt to make a diagnosis before deciding on treatment. Yet when we were given the opportunity to look after a patient (society) with a symptom (long waiting times) we made no attempt to determine the diagnosis, but rushed to decide on a remedy based on "balancing" public and private healthcare sectors.

If we go back to first principles we see three mechanisms which give rise to long waiting times: inadequate treatment facilities (physical and/or personnel), excessive demand (more than justified by evidence-based diagnostic /therapeutic criteria), or organizational inefficiency (failure to match available resources with patients in need). Each of these mechanisms may be of major importance at different times and in different locations. Consequently there can be no single solution to the waiting problem. The CMA made no attempt to determine the relative importance of these mechanisms and how best to deal with them as specific problems.

2. In the fall of 2005 the president sent a questionnaire to each member of the CMA to determine prevailing attitudes toward public and private

healthcare. Sixty-two per cent of respondents opted for a completely public system or a public system with privatized care only under specific conditions; only 27 per cent opted for a purely private system or for complete freedom of choice. This strong support for the public system, coming directly from the members was not referred to again.

3. A second questionnaire was distributed to provide input into a subsequent "position paper". This consisted of five issues involving the public-private sector split, and a number of statements about the issue.

This "physician's guide for discussing the issues" is based on a false premise (see endnote) and a number of the questions appear designed to elicit responses which favour the expansion of the private sector. Given the membership support for the public system, and the president's statements that the CMA supports a strong publicly-funded healthcare system, how do we justify the leap from a concern with waiting times to a narrow focus on public/private funding, public/private partnerships, contracting out etc.? If we support a strong publicly-funded system, why have we ignored the possibility of changing this system without bringing in the private sector?

4. The discrepancy between the members and the delegates is striking: 95% of the members supported the principle that access to care must be based on need, not ability to pay, while the delegates rejected a motion that supported (indirectly) the same principal.

These events and actions lead me to believe that the leadership of the CMA had decided to support the

path of increased privatization before the process of "consultation" and preparation of the position paper was begun. I hope you can show me that this is not true.

Norman Kalant MD, PhD

DR. MCMILLAN'S RESPONSE

...As you suggest in your letter, there is no single solution to the waiting time problem in Canada. CMA has made it a strategic priority to look at how best to improve access to high-quality health care in Canada by better managing the public-private interface. However, we recognize that improved access to health services goes beyond public-private issues. As stated on page 17 of the publication *It's About Access*, "improving access to care for patients is a multi-faceted challenge that cannot be accomplished solely by improving how the public and private sectors interact." The paper then goes on to enumerate several other factors, including prevention, health human resources, appropriate and efficient use of resources, alternate funding and practice models, etc., that must be part of any strategy to improve access.

CMA's policy continues to be that we support a strong, publicly funded health care system. Delegates at the CMA's 2005 annual general meeting in Edmonton stressed that patients need access to safety valves when timely access to care cannot be provided. In CMA's version of this safety valve, a publicly funded Canada Health Access Fund would pay for out-of-province or out-of-country private care after maximum established wait-

(continued on page 15)

ENGAGING THE CANADIAN MEDICAL ASSOCIATION (continued)

time benchmarks have been exceeded. Resolutions passed at this year's annual meeting confirm the support for a publicly-funded system.

In your letter, you also state that you believe "the leadership of the CMA had decided to support the path of increased privatization before the process of consultation and preparation of the position paper was begun."

I want to assure you that the CMA drafting committee, charged with working on the discussion paper and policy principles about the roles of the public and private sectors, did take into consideration the comments and suggestions received from the more than 3,000 members who responded to CMA's request for input. In fact, the publication of the CMA document It's

About Access was delayed, pending the compilation of member comments.

Dr. Kalant, on behalf of the CMA, thank you for your ongoing membership, your valuable input and for helping us represent the views of the doctors of Canada. ♦

Yours sincerely,

Colin J. McMillan, MD, CM, FRCPC, FACP

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
- \$60 Affiliate (out of province) physician Intern / Resident / Retired / Part-time Organization
- Free Newsletter Subscriber E-Newsletter Subscriber 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

HEALTH PROVIDERS AGAINST POVERTY

Toronto area health providers are continuing to work with anti-poverty advocates to keep the dismal situation of social assistance recipients on the public policy agenda. And they've been given a vote of confidence by the George Cedric Metcalf Foundation Charitable Foundation for a project proposal called Bringing Health to Poverty.

This novel project is designed to develop capacity among Ontario health care providers and health professional organizations to target poverty, and our grossly inadequate social assistance rates in particular, as a health issue.

The project includes the development of a policy paper on poverty and health, and an information and media kit, both of which will be

used to educate and empower health providers, their professional organizations, and other individuals and groups working to end poverty.

The second phase of the project will involve the dissemination of this material, and ongoing communications and media work to focus the public policy debate on poverty and low social assistance rates as major determinants of health in Ontario, particularly in light of Ontario's first fixed date election set for October 4, 2007. This approach contributes a fresh, respected, and powerful perspective to the public policy discussion on reducing poverty in Ontario.

The proposal is a joint undertaking of the Regent Park Community Health Centre and Health

Providers Against Poverty, and is supported by the Medical Reform Group. The award from the Metcalf Foundation is \$79,995, and the project is expected to run from January 2007 to April 2008.

For more information and to get involved, contact us at medicalreform@sympatico.ca. Health Providers against Poverty are particularly interested in hearing from members with recommendations and/or contacts for dissemination. ♦

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

*Please visit and comment on our web-site at <http://www.hwcen.org/link/mrg>
Please also make a note of our current contact information as follows:
(416) 787-5246 [telephone]; (416) 352-1454 [fax]; medicalreform@sympatico.ca [e-mail]*