

Medical Reform

Newsletter of the Medical Reform Group

Issue 141

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Summer, 2007

WHAT WILL BRING SANITY TO THE DEBATE ON DRUG COSTS?

EE Daniel provides this concise analysis of issues to be addressed by a national pharmacare strategy

More of the expenditures of Big Pharma in the USA in 2004 were not for research but for drug promotion (estimated at about 24.4 per cent of the sales dollar versus 13.4 per cent for R&D¹). US \$57.5 billion was spent on marketing, which includes drug detail salespersons visiting doctors, giving samples to doctors, TV ads, advertising in journals to doctors and in magazines to patients, payments to consultants to travel around and tell doctors about their drugs², etc. Proportionately more is spent on marketing what are known as “me too” drugs in the USA, where advertising of claims for prescription drugs to patients in the media is allowed.

The expenditure per capita on prescription drugs is much higher in the USA than in Canada. The differential, previously small, increased after 1995 when US pharmaceutical firms began to use television ads to market drugs with product-claims advertisements (ads supposed to contain also information about major side effects and contraindications and information to allow access to detailed labeling information).

The differential grew even faster after 1997 when the guidelines

for these ads were changed to require, besides the claims, a statement about risks and reference of consumers to 4 sources for further information; a toll free telephone number, currently running print advertisements, a brochure and the consumers health provider³. Between 1995 and 2005, the average difference in per capita spending on prescription drugs in the USA compared to Canada increased from Canadian \$2 to Canadian \$356.

This increase was in lockstep with increased expenditure on direct

to consumer advertising of prescription drugs. Thus direct promotion of prescription drugs to consumers constitutes a major component of costs to pharmaceutical firms in the USA. In Canada, CanWest Global is trying to open the media markets to drug claims promotion, but the case, currently before the Ontario Superior Court, has not been decided. The consequences of allowing prescription drug claims ads in Canada will certainly be similar to those in the USA, increased per capita costs without public health benefit.

Drugs costs are also the result of their heavy promotion as the solution to all problems in what can be described as “Treating desires not diseases”⁴.

Professor David Triggle at the University of Buffalo described it thus: “The 1 April 2006 issue of The British Medical Journal ran a short note by the Australian journalist Ray Moynihan describing a new disease - motivational deficiency disorder. Apparently affecting one in five Australians and diagnosed by neurologist Leth Argos through both positron emission tomography scans and scoring scales, the disease was described

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Medical Reform

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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, Rosana Pellizzari, Janet Maher

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

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

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

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

EDITORIAL NOTES

Janet Maher

The character of our work is changing gradually as the composition of the Steering Committee changes, as can be seen from a review of contributions to our last several issues.

In particular, the fact that the steering committee has welcomed and supported the issues of students and residents is evident in recent coverage of the SAFER Campaign to address sexual violence in the Democratic Republic of the Congo. Many of the family physicians who work with other anti-poverty advocates as Health Providers Against Poverty have made their presence felt in these pages. As well we continue to have requests from long-standing members to support coalition campaigns they expect are of interest to our membership.

Following discussion of one of those requests to endorse a coalition activity expected to be of interest to some members, Steering Committee member Norman Kalant volunteered to review the MRG archives on this policy setting issue and report back for the newsletter.

This he has done, with the recommendation that we consider a resolution process at semi-annual meetings to confirm or ratify recommendations of the Steering Committee between the semi-annual meetings. We are very interested in feedback on this item—the process of policy making in the MRG, and specifically call on members to write or call.

Readers might also note that the lead article on drug policy comes from a long-time MRG member who is not a member of the steering committee. We welcome feedback on the value of seeking additional member input, either in letters to the editor or contributions such as that of Dr. Daniel.

In other news, we had many compliments on the coverage in our spring 2007 issue in tribute to founding member Mimi Divinsky—members may be interested to know that a Special Diet Clinic held April 28th in Toronto in Mimi's honour provided special diet assessments for some 200 families.

We have a copy of a tribute video to Mimi made by her friend, filmmaker Helga Haberfellner, which is available for borrowing by members. Health Providers Against Poverty is still considering ways to honour their colleague's memory in a more permanent fashion.

Finally, we look forward to the fall issue of **MEDICAL REFORM** and contributions from some of our members who spoke at the May, 2007 SOS Medicare 2 conference in Regina as well as opinion pieces on other current issues. ♦

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as treatable with a new cannabinoid CB1 receptor antagonist indoleban.

“Several news organizations ran with this story, accepting it as authentic. Motivational deficiency disorder fits in with restless legs syndrome, female sexual dysfunction, social anxiety disorder, intermittent explosive disorder, irritable male syndrome and other assorted contemporary ‘diseases’.” Trigg added, that it also fits well with the barrage of pharmaceutical advertising that viewers of US television are subject to.

The demographics of a TV program audience can be predicted by looking at the drug advertisements: advertisements for ‘leaky pipes’, insomnia and erectile enhancement implies an audience of more than 50 years.

The Current Situation in Canada

Already, total expenditures on drugs in Canada amounted to \$24.8 billion in 2005. That was more than was spent on doctor’s services. Most of these costs were for prescription drugs (about \$20.6 billion). The cost of drugs is growing at about 12 per cent annually. In 2005, the public sector paid about 50 per cent of the cost of prescribed drugs, \$ 9.5 billion⁵. Unfortunately, the increasing costs are not due to new breakthrough drugs, but to more and more “me too” drugs⁶.

The growing epidemics of obesity and related health problems (diabetes), high incidences of myocardial infarction and stroke, and age related diseases (Alzheimer’s dementia, heart failure, osteoporosis, cancer, etc) will increase the need and demand for drugs. As the proportion of aged persons increases, the

demands will multiply. These factors, together with the promotion of a pill for every problem, mean that drug costs, if unchecked, may overwhelm the Public Universal Health Care we enjoy. The question is, what will control drug prices?

The Role of Patents

In 1993, Bill C91 gave new drugs patents for 20 years in Canada, retroactive to 1991, and set up the Patented Medicine Prices Review Board (PMPRB). Before then, compulsory licensing allowed a company to manufacture a generic copy of a patented drug after varying, but shorter, periods of time. The change was justified by claiming that this would enhance pharmaceutical research and drug development in Canada.

There was an increase in the percentage of the sales dollar that went to R&D from 1987 (about 6 per cent) to a high of about 12.9 per cent in 1997 but since then the portion of the sales dollar that goes to R&D has dropped to about 8 per cent. Moreover, the extent of deficits of imports into Canada over exports of prescription drugs rose from \$1.5 billion in 1993 to \$4 billion in 2000.

The exact causes are unknown, but problems of scale and the impacts of NAFTA and the WTO played roles. The proportion of prescription drug imports has risen from 34 per cent in 1993 to more than 75 per cent by 2000⁶. Thus Bill C91 has not increased the Canadian content of the drugs we consume.

What Doesn’t Work to Control Drug Costs

Free marketers will say, “Competition will control prices”. However the evidence is clear: the market fails to control drug prices, i.e., there is no effective price competition between brand-name drugs that do the same thing or between brand-name and generic drugs (copies of drugs made after patent expiration⁷)?

The explanation: Canadian regulations and policies under the (PMPRB) allow a newly patented drug to be priced up to the maximum price of existing drugs that are therapeutically the same and drug companies take full advantage⁸. Although this has not been studied, I suspect that they compete in advertisement costs rather than in price.

If a drug is covered under a provincial drug plan and the plan lists generic equivalents then, in all provinces except Quebec, pharmacists are only paid for the least expensive version listed regardless of what the doctor prescribes and what the pharmacist dispenses. Big Pharma tries to get around this market erosion by bringing different formulations onto the market and patenting them just before the generic drug appears or else they sell their own generic version. Thus when generic drugs finally become available, expenditures for drugs may not go down much or at all.

Also, much money is spent by Big Pharma to ensure that generic drugs do not take over the market. So far, they are succeeding⁷, even though the prices for generic versions of drugs are usually set about 25 per cent lower than brand name drugs
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by provincial drug plans. In the USA, Big Pharma sometimes pays generic manufacturers to keep their drugs off the market⁹.

The conclusions are that drug prices are not successfully controlled by the market, that Canada has become a major importer of prescription drugs and that any price advantage that Canadians have over the USA and most of the EU results from controls exerted by the PMPRB. However, prices in France, Italy and Sweden are lower than in Canada. Finally, if attempts to allow direct to patient advertising are successful, drug expenditures will increase dramatically.

What Will Work to Reduce and Control Drug Costs?

The simplest and most effective approach would be for the federal government to set up a universal Pharmacare system to buy drugs. Provinces already do this when buying drugs for their public plans, but a single national negotiator would have more leverage and a universal plan would reduce costs per patient and overall costs.

The individual consumer of drugs, paying privately, has little or no power to bargain at the pharmacy and no ability to influence prices set by Big Pharma. He/she lacks the information to demand or accept a generic substitution, even when they must be offered as they are in some provinces.

The bargaining power of the federal governments would be greater than that of individuals or even provinces. That is why in the USA, Medicare is prohibited by the law, demanded by Bush and passed

by the Republican Congress, from “negotiating” drug prices.

Under a Pharmacare Plan, the federal government could establish a drug formulary based on the best evidence about which drugs are effective and safe for various diseases. Then where there are generic versions of a drug the government could place tenders and award the contract to the company with the lowest bid.

Where there are multiple different but very similar drugs (virtually identical in terms of safety and effectiveness), then the government would pay for the least expensive product in the class. Even in the rare case of real breakthrough drugs, the ability to buy on a large scale would enable the government to bargain effectively.

Consumers could still have choice if they or their physicians chose to disregard the evidence that led to the government’s choice of which drug to pay for when there are generic or multiple similar products. In these cases the consumer could elect to pay the difference between the product that she/he wants and the one the government covers. When patients need a more expensive drug because of genuine medical need then the government would pay the entire cost. British Columbia has been successfully running such a Reference Based Drug Program since 1995.

There should also be a major attempt to educate doctors and patients about drug intake, to curb the increasingly irrational and counterproductive abuse of drugs noted by Professor Triggle. Such a system can have problems of course; for example, what about very expensive and/or new breakthrough drugs needed for

rare cases of cancer or genetic conditions.

There would have to be an Appeal System to decide how to respond to these cases. Sometimes difficult decisions would need to be taken. One drug may save a life of a teenage person while another may extend it for a few months for an elderly person. A fair mechanism, not hampered by major bureaucratic delays, will have to be developed to make these difficult decisions.

The Biggest Problem: Provincial versus Federal Jurisdiction

Health care is under provincial jurisdiction, and provincial governments are highly suspicious of any action that they interpret as an attempt by the federal government to interfere with their turf. This will be the biggest obstacle to setting up a National Pharmacare for Canada.

However, there may be approaches that will achieve cooperation in this endeavor. For example, our national government could set up an inter-provincial group of experts to work together on a National Formulary. Participation would of course be voluntary, but provincial Medical Associations could be asked to send representatives.

Once a National Formulary, with an amending mechanism, is in existence, then the National Government could offer to interested provinces to negotiate prices with the pharmaceutical industry on drugs in the Formulary. Again participation would be voluntary, but experience should quickly reveal that the bargaining power of the National Government results in lower prices. Once this

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has been demonstrated, additional mechanisms to negotiate prices for new drugs which are truly innovative could be put in place. The above proposal is only one of several ways that a National Pharmacare system could be introduced.

Conclusion

For the future of Universal Medicare, and for improved delivery of pharmaceutical care at reasonable cost, it is time for Canada to set up a National Universal Pharmacare Program. Although obstacles exist, they can and must be overcome to ensure that Universal Medicare survives the onslaught of high drug costs. ♦

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Dr. Ed Daniel, wounded in action in World War II, has a distinguished lifetime record of nearly 800 peer reviewed contributions in pharmacological research. He is currently Emeritus Professor of Medicine at McMaster University and Adjunct Professor of Pharmacology at the University of Alberta.
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EMERGENCY CONTRACEPTIVE PILL PLAN B NOW AVAILABLE WITHOUT A PRESCRIPTION IN BC

Two years after Health Canada approved the use of the emergency contraceptive pill Plan B for sale directly from pharmacies without a prescription, Options for Sexual Health is pleased to hear that the BC College of Pharmacists is now following the federal recommendation.

BC pharmacists have been dispensing Plan B since 2001 as a prescription medication. Until now, though, they have been required to have specialized training to do so, and to consult extensively with the client prior to prescribing and providing the medication.

On Friday May 25th, the BC College of Pharmacists released

medical information for its members regarding the change in how Plan B is regulated. Plan B is now a non-prescription product and will be available behind the counter from all pharmacists, like many other medications for which the consumer may need supplementary product information.

Options for Sexual Health (OPT), BC's largest sexual health services provider, hopes that the change will dramatically increase access to Plan B in BC. Consumers will no longer be required to pay the \$25 consultation fee pharmacists charged them in addition to the \$25 cost for the product, while the drug was still a prescription product. Those who

qualify for PharmaCare will now receive an additional price reduction for the product. This will mean that the cost of accessing Plan B will now be brought much more in line with the \$15 total cost that OPT has charged in all of its 50 BC clinics since Plan B first became available here.

Plan B will now also be available to individuals who would like to keep emergency contraception at home so that it is readily available for future use, and to men who want to purchase it for their female partners. "We're delighted this product can now be sold to men, as an additional way they can play a role in preventing unplanned pregnancy,"

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EMERGENCY CONTRACEPTIVE IN BC (continued)

says Greg Smith, Executive Director for Options for Sexual Health. May 25th's change in policy brings this province one step closer to pregnancy prevention on demand.

Plan B, comprised of the drug Levonorgestrel, can be used by women following unprotected intercourse to reduce the risk of pregnancy by up to 89 per cent. It is most effective the sooner it is taken after unprotected intercourse, but can be used up to five days to prevent pregnancy. Plan B works in one of three ways: preventing the release of an egg from the ovaries; preventing the fertilization of an egg by sperm; or by potentially preventing the implantation of a fertilized egg in the uterus. ♦

Released May 31, 2007 by B.C. Options for Sexual Health

UPDATE ON WOMEN AND HEALTH PROTECTION EMERGENCY CONTRACEPTION FILE

Janet Maher from files

In late 2005, the Medical Reform Group Working Group on Reproductive Health joined with Women and Health Protection (WHP) and the Canadian Women's Health Network (CWHN) on a submission to the National Drug Scheduling Advisory Committee (NDSAC) establishing a case for the de-scheduling of Plan B, the (levonorgestrol-only) emergency contraception pill [see **MEDICAL REFORM**, Issue 137]. This request to NDSAC was denied.

The partnership received endorsement from over 70 individuals and organizations across Canada for a submission which was forwarded to the National Association of Pharmacy Regulatory Authorities (NAPRA) for consideration at their April 23, 2006 meeting. The group—WHP, the CWHN, the Society of Obstetricians and Gynecologists of Canada and the Canadian Federation

for Sexual Health – requested that NAPRA encourage NDSAC to review this submission in the name of public interest (that is, without having to pay the large fee). On May 2, 2006, Women and Health Protection received a formal reply from NAPRA, indicating that our request had been defeated. We wrote requesting further clarification and received a follow-up response on May 24, 2006. As it stands, the only way that NDSAC would consider a submission from our coalition the requisite fee of \$37,000 were paid.

For the present, we are monitoring the activities of NAPRA and NDSAC to determine if there may be an opening in the future to re-consider our submission on a public interest basis. We will continue to monitor this issue closely, particularly in view of the British Columbia decision reported in this issue. ♦



SPRING MEMBERS MEETING

Janet Maher from notes

April 30th was the occasion for a joint meeting between the Medical Reform Group and Canadian Doctors for Medicare members to explore areas for collaboration over the coming year. Ahmed Bayoumi made a short presentation on behalf of the Medical Reform Group, as did Danielle Martin on behalf of Canadian Doctors for Medicare.

Bayoumi's presentation, *Winners and Losers* reviewed the evidence for privatization of health care services primarily from the point of view of who gains or stands to gain and what measures they might take to maximize their position. In brief, he answers the question by noting that investors are seeking new markets, and are seeking to persuade the public that the publicly funded system is broken, in that:

- ◆ Medications are not funded
- ◆ Waiting lists are too long
- ◆ Prevalence of free riders [inappropriate use of emergency rooms]
- ◆ Health care accounting for ever larger shares of government budgets
- ◆ Private insurance can solve this by taking pressure off the public delivery system

Bayoumi provided careful rebuttal of each of these items, affirming that expenditures are not out of control and there is little systematic evidence of either free riders or cream skinning. Rather, he argued, it is the concepts of social insurance and public investment which are under threat. He concluded urging members to refocus on messaging to focus on the equity and

efficiency advantages of social insurance over private insurance.

Martin reviewed a Canadian Doctors for Medicare presentation she has designed for presentation to clinical and academic audiences. After a brief summary of recent public consultation on the future of health care (Romanow, Kirby) and some of the recent work of the Health Council of Canada, like Bayoumi, she concluded that health care funding in Canada is near the average for all OECD countries, and which health care spending has increased over the past decade as a share of government spending, this is more a product of the shrinkage of public spending; in comparisons of health care spending as a percentage of GDP, the change is imperceptible—and can be attributed predominantly to the inflation of drug costs.

Referring to a systematic review of health outcomes recently completed by Guyatt and his team, and a 2006 US study by Lasser et al., she found little evidence for any advantage to be gained by allowing a parallel private system. In particular her assessment of the lessons of Europe and Australia suggested that there was limited scope for cost savings; no guarantee that increasing private financing would have any effect on wait times in the public system and, most critically, no simple way to regulate private insurers in the public interest.

At the end of the day, she concluded as did the Canadian Medical Association in its discussion paper *It's About Access!* that although private health insurance can provide greater choice and access to services

for those who can afford it, it has not been found to improve access to publicly insured services, lower costs or improve quality. Moreover, this strategy does nothing to address some of the most frequently cited risks:

- ◆ Departure of scarce health human resources from the public system and higher doctor-patient ratio in private care settings
- ◆ Erosion of public support for maintaining the quality of publicly funded care as wealthier move to private care
- ◆ Potential for the private system to cream skim the least sick patients, leaving greater burden for public system.

The presentations gave rise to a lively discussion and agreement to continue discussions on the most productive ways to collaborate. Both Bayoumi's and Martin's powerpoint presentations are available from the office at medicalreform@sympatico.ca ◆

Health Providers Against Poverty

Janet Maher

As noted in our Winter 2007 issue, Health Providers were successful in a grant application to the George Cedric Metcalf Foundation to assist in getting the health impacts of poverty on the public policy agenda through the coming provincial election campaign in a 15-month project called Bringing Health to Poverty.

Over the first six months, the project has focused on bringing together two kinds of resources:

1. Compiling clinical evidence of the impacts of poverty on health. Proceeding from a paper prepared by Regent Park CHC Nurse Practitioner Kathy Hardill in January, 2006, we now have a paper which is ready for submission to the CMAJ.
2. Providers from our steering committee have also been

hard at work preparing a series of fact sheets as resources for clinicians who deal with social assistance in their practice or in the so-called Special Diet Clinics.

Outreach has also been done with similar groups in Hamilton, Kingston, Ottawa and Peterborough—and there is room for more.

As possible, Toronto area providers have been making themselves available for presentations at conferences and other meetings where the data are presented, and participants engaged in discussions on the roles they can play in improving the quality of life of the most vulnerable Ontarians. Presentations have been made to the Registered Nurses' Association of Ontario, the Association of Ontario Health Centres, as well as clinical rounds in the Greater To-

ronto Area, the Community Dietitians Network and other provider groups.

Further sessions are planned for fall meetings of the Ontario Public Health Association, among others, and we are already strategizing with groups in other regions about advancing a legislated poverty reduction strategy as a provincial election demand.

Preliminary steps have also been taken to focus public attention on this by collaborating with the Registered Nurses' Association of Ontario and the Income Security Advocacy Centre to co-sponsor a high profile provincial leaders' debate in Toronto in the last week of September.

For more information contact Coordinator Janet Maher by e-mail at medicalreform@sympatico.ca. ♦

CAMPAIGN 2000 PARTNERSHIP

Janet Maher with notes

Members will have noted sporadic news in these pages on Campaign 2000, an advocacy effort that owes its origins to the 1989 parliamentary resolution in honour of Ed Broadbent's first retirement—when the House of Commons voted unanimously on their intent to eliminate child poverty by the year 2000. Instead, as we know, government preoccupations with debt and deficit reduction have resulted in more, not less, poverty among all age groups except seniors.

In our last issue we noted the increasing interest in the voluntary sector in directly addressing this issue

through, for example by the National Council of Welfare by specific poverty reduction legislation. In Ontario, the main energy for this effort has come from Ontario Campaign 2000, and so we have begun to work with them in setting out a policy framework which addresses all of our concerns.

As noted in Norman Kalant's article elsewhere in this issue, participation in this kind of coalition has historically been an issue for a members meeting, and it will be on the agenda for our fall meeting. However, we are proceeding working with the coalition—which is committed to

ending child and family poverty in partnership with provincial organizations such as the Elementary Teachers' Federation of Ontario, the Ontario Association of Social Workers and the Ontario Public Health Association and local organizations such as the Hamilton Social Planning Council, North Bay Labour Council and Health Providers Against Poverty—in the interim because of the opportunities for raising the profile of poverty in the coming provincial election.

Along with other Campaign 2000 members, we reviewed a draft

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MONITORING TORONTO'S RESPONSE TO THE SPECIAL DIET CAMPAIGN

Janet Maher sent the following message to City Councillor Joe Mihevc, Chair of the Recreation and Community Services Committee on behalf of the Medical Reform Group on May 15, 2007 with copies to Dr David McKeown, Toronto Medical Officer of Health and Dr. Gary Bloch of Health Providers Against Poverty. While we understand the city continues to bear an unfair burden as a result of provincial downloading, members continue to be concerned that this burden is passed on to social assistance recipients through a range of bureaucratic tactics. By press time, we had not had a response..

Further to my message of February 19th, to which we received a circular response on March 14th, 2007, I am writing again on behalf of the Medical Reform Group. As I indicated in February, many of our members work with low-income individuals and families on social assistance; they have been active in providing health-related information for Toronto councillors over the past couple of years at the Board of Health and at Recreation and Community and Neighbourhood Services.

When we got the message of March 14th, we applauded its breadth in supporting not only our specific requests around appropriate management and training of front-line social services staff who deal directly with social assistance recipients, but also in endorsing a number of related campaigns and initiatives.

We were therefore particularly dismayed to hear from recipients in the past month that application forms for special allowances which had been filed for recipients by some of our members were being turned back for lack of a physician's stamp, despite the fact that there is no mention in the relevant regulations of the requirement for such a stamp.

I wonder if there is a more productive way of pointing out to city staff that the physician stamp does not in fact have any basis in any law—but has been adopted as a common practice and an aid to physicians whose opinions are frequently sought to confirm health status or eligibility for certain entitlements by authorities at all levels.. In reality the stamp is a convenience, an easy/efficient way to get the provider's address on the form, but it can be and often is handwritten without sanction.

The Medical Reform Group has long advocated for an approach to health and health care which recognizes the determining role of adequate and secure income, as well as other non-medical factors in maintaining the good health of families and children and allowing them to focus their attention on activities to improve health, rather than scrambling continually to ward off landlords and other bill collectors as they struggle to feed, clothe and maintain their children in school.

Some of our members have devoted virtually their entire working life to demonstrating how a preventive approach can moderate the need for continuing increases in acute health care spending. If it would be of assistance, I'd be pleased to arrange for a small group to provide a comprehensive briefing on this issue for councillors and managers who could then ensure that this information is widely disseminated throughout the system.

We are also mindful that a real poverty reduction strategy is best proposed and implemented at the provincial or national level. The City Clerk's message of March 14th had given us to believe that you and your colleagues shared that analysis and might be an ally and provide leadership and hope for some of the most vulnerable Torontonians.

I continue to hope this is the case and look forward to your early and positive response. ♦

CAMPAIGN 2000 PARTNERSHIP (continued)

strategy—the final document will be from July 13th, when it is slated to be available on the campaign 2000 released publicly. ♦
website at www.campaign2000.ca

ALLIANCES WITH OTHER GROUPS

Norman Kalant

A year ago, during the heavy fighting in the Middle East, with constant rocket attacks on Israeli settlements and constant shelling of Palestinian villages in Gaza and of southern Lebanon, a number of petitions were circulated seeking support for a particular view of the hostilities.

When one of these was submitted to the Steering Committee, there was a sharp difference of opinion regarding the appropriateness of the MRG taking a position in such a matter.

Those in favor of signing the petition were of the opinion that our mandate as a left-wing organization is quite broad and implicitly would encompass support of statements based on fundamental human rights. Those opposed to signing considered the issue unconnected to our mandate. It was therefore clear that there are fundamental differences of interpretation of our statement of the purpose and goals of the MRG.

Our records reveal a Statement of Principles to which we are dedicated (rather than a constitution, a mandate or a statement of goal or purpose). These are:

1. Health care is a right
2. Health is political and social in nature
3. The institutions of the health system must be changed

From these principles it is quite clear that our prime concerns are the health care system, population health, and the organizational structures for the provision of healthcare. It is to be noted that none of the principles is directly concerned with concepts

of human rights, or social justice in a broad sense.

The Statement contains a further commitment: the MRG will ally itself with the struggles of other health care workers on an independent fraternal basis. This would cover alliances with organizations such as Canadian Doctors for Medicare as well as being signatory to a petition in support of other health care workers.

During the discussion at our May 2007 Steering Committee meeting, there appeared to be consensus that limits to alliances or expressions of support are imposed by the size of our organization and that such affiliations would be most effective at the local level than at a national or international level.

In conclusion, the Steering Committee recommends that our affiliations, alliances or expressions of support for other groups or organizations be first considered by two criteria:

1. The allied organization is primarily concerned with aspects of healthcare or population health. The specific issue for which the alliance is formed is directly related to healthcare or a health matter and is not dependent on a secondary or tenuous link to health.
2. Priority for alliances will be given to local organizations. ♦

Steering Committee member Norman Kalant is a retired physician and researcher from Montreal who has recently relocated to Toronto.

HEALTH CANADA COST RECOVERY INITIATIVE

Janet Maher from notes

The issue of industry user fees paying for a significant portion of the drug approval process continues to be under the microscope in Canada and the U.S. Health Canada invited public feedback on this issue in an on-line survey earlier this spring. The Medical Reform Group responded on May 12th, 2007, indicating our continuing concern on the compromises implicit in this approach to health protection, in which one of the major stakeholders is expected to fund a significant proportion of the drug approval process.

The inherent problems of industry fees paying for drug approval and post market surveillance are ones many of us have been voicing our concerns over for years and yet the government appears to be barrelling ahead with more of the same.

Joel Lexchin has written extensively about this issue and cautions that, "while there are timelines for things like how long it should take drugs to get through the approval cycle (and penalties if these times are exceeded), there are no agreed upon timelines for things like how quickly safety signals should be acted on. Therefore, there is pressure to put resources into the former at the expense of the latter." ♦

OPEN MEDICINE OFF TO A GREAT START: CANADIAN HEALTH CARE FAR BETTER DEAL THAN U.S.

The inaugural edition of the new Canadian medical journal, *Open Medicine*, includes a groundbreaking article from a group of prominent Canadian and American researchers.

"Canadian health care produces as good or better outcomes than American care at half the price," MRG spokesperson Dr. Ahmed Bayoumi said today. "The new study shows that moving toward private pay, or for-profit delivery, will spell disaster for Canadian medicine."

The new study is a systematic review that pulls together all research articles that directly compared the outcomes of care in Canada and the United States. In every area, whether

in cancer care, major operations, or cardiovascular disease, Canada held its own or did better. Canadian outcomes were consistently better for patients with end-stage kidney disease.

"The researchers have done an outstanding job of producing an unbiased summary of the best evidence," said Dr. Bayoumi. "Their methods are pristine, and the message is clear. What Canadian health care has achieved is remarkable: Health outcomes as good or better than the U.S. achieves, at half the price."

The article appears in the new Canada-based journal, *Open Medicine*. The new journal grew out of the controversial firing of Canadian

Medical Association Journal editors John Hoey and Anne-Marie Todkill, and the deep concerns about academic and journalistic freedom that the firing raised.

"Open Medicine represents an important new voice on the Canadian health care scene," said Dr. Bayoumi. "They are starting off with a crucial article that doesn't deny the problems in Canadian health care," Dr. Bayoumi concluded. "What it does tell us, is that if we are smart, we will find solutions by strengthening and extending public payment, and not-for-profit delivery." ♦

Released by the Medical Reform Group April 18, 2007

MRG TO HARPER: PUSH BACK TO QUEBEC

The Quebec provincial government is openly pushing for two tier health care, including modification of the Canada Health Act. Stephen Harper has claimed he is a strong supporter of the Act, and of universal health care.

"The Medical Reform Group is challenging Mr. Harper," said MRG spokesperson Dr. Ahmed Bayoumi. "If you really believe in high quality health care for all, now is the time to show it."

For years, neither the previous Liberal nor current Conservative government have been aggressive in enforcing the Canada Health Act. The result is a quiet move toward two tier care in Quebec, Alberta, and British Columbia. Governments have allowed those who can pay to jump to the front of the queue for diag-

nostic imaging, and surgeries such as joint replacement. Meanwhile, they have publicly claimed to be Medicare supporters.

The Quebec action is something new. The government is openly endorsing U.S.-style two tier care. "If Mr. Harper chooses to push back and defend the Canada Health Act, he is on very strong ground," said another MRG spokesperson, Dr. Shelly Sender. "Public payment for health care is not only more equitable, but more efficient, and better for Canada's economy."

"Only the rich, and those who make money from delivering health care, will benefit if the government allows the move to private pay," Dr. Sender continued. "Overwhelmingly, ordinary Canadians will be the big losers."

"Will Mr. Harper prove that he really has changed, or will he welcome the Quebec initiative to advance a so-far quiet privatization agenda?" Dr. Bayoumi asked in conclusion.

"Does Mr. Harper believe that Canadians should receive care according to need, and not ability to pay, or does he not? If Mr. Harper is really a champion for high quality health care for all Canadians, he must push back aggressively against Quebec's privatization move, and he must do it now." ♦

Released by the Medical Reform Group, May 25, 2007

CHARTER CHALLENGE AGAINST SINGLE-TIER HEALTH CARE IN ONTARIO

Ontario Health Coalition Backgrounder, May 2007, with files from Natalie Mehra

According to a press conference held this month, the Canadian Constitution Foundation (CCF) is funding a Charter challenge to single tier Public Medicare in Ontario. This group also launched a class action against single tier in Alberta last year.

The goal appears to be to extend the Chaoulli decision outside of Quebec to bring down the ban on two-tiering and to widen the opening for two-tier Medicare, extra-billing, user charges and out-of-pocket payment for medical care.

The Ontario lawsuit, conducted in the name of Lindsay McCreith, challenges the province's Health Insurance Act, the Commitment to the Future of Medicare Act, and the Healthcare Accessibility Act, and seeks to have the court order the province to allow extra billing by doctors and companies for essential services. McCreith allegedly was diagnosed with a possible brain tumor but was told he would have to wait 4 + months before an MRI could be conducted to confirm the diagnosis. Instead of waiting, he went to Buffalo where allegedly an MRI confirmed that the tumor was malignant.

The CCF has begun an extremely disingenuous streetcar advertising campaign in Toronto which blames a 'healthcare monopoly' — ie. the public health system — for almost killing a patient, despite evidence that wait times, or rationing based on urgency and supply, are not just products of public systems — but occur in either public and private systems.

Ignored by the pro-privatizers, is the fact that there is no measure-

ment of waits when there is no health system — when health care is treated as a private market for those who can afford it. In the U.S. 45 million citizens are uninsured and unable to afford to even stand in the queue, and millions of others are trumped for a place in the queue by wealth.

Who is Behind the Pro-Privatization Campaign?

The Calgary-based CCF is an extremely right-wing legal advocacy organization (and registered charity) that uses Charter challenges and public campaigns to promote its vision of "constitutional freedom"—specifically individual and economic "freedom", property rights and the restriction of government—and to defend the Constitution against "improper decisions or actions of governments, regulators, tribunals or special interest groups." The CCF is radically ideological and strongly linked with other right wing causes and organizations, most notably the Fraser Institute.

The CCF was founded in 2002 by lawyer John Weston of Vancouver to fund James Robinson's legal challenge to the Nisga'a Treaty (an aboriginal land claim in B.C.). Weston left the CCF and the Robinson case in 2005 in order to focus on his political ambitions as a federal Conservative candidate in West Vancouver (he was narrowly defeated in 2006 despite the support of Dr. Michael Walker, former Executive Director of the Fraser Institute). The CCF hired John Carpay, a former Reform candidate and the Alberta director of the Canadian Taxpayer

Federation, to be the CCF's new Executive Director. The organization relocated to Calgary and re-launched itself in the summer of 2005.

Philosophy

While many conservatives loathe the Charter of Rights - viewing it as having allowed left-wing judicial activism - the CCF's strategy is to 'expropriate' the Charter and use it to promote their right-wing 'liberty and property' conservative agenda. Speaking about the Charter, Weston told the Calgary Herald in 2005 "it's here, there's not much point in wishing it weren't. Now we need to make it mean what it's supposed to mean. Conservatives must reclaim it for conservative values." The CCF appears to emulate other right-wing legal lobbies in the US such as the Institute for Justice.

Types of Cases the CCF Takes Up

Aside from its continuing legal challenge to a long-awaited aboriginal land claims treaty (which has been described in the Vancouver Sun as "a stalking horse for ultra-conservative ideologues with little support or credibility") the CCF has also supported a successful challenge against a New Brunswick user charge on liquor sales in bars and is currently funding a class action legal challenges to Medicare in Alberta and an individual action in Ontario. The CCF also hailed the scrapping of the Court Challenges Program that funded court challenges by disadvantaged groups. ♦

TORY HEALTH PLATFORM A RECIPE FOR PRIVATIZATION: ONTARIO HEALTH COALITION BRACING FOR CONFRONTATION IN ONTARIO ELECTION

John Tory's Conservatives intend to hand our non-profit hospital and health services to for-profit companies, is the message in today's release of the Conservative health platform.

"John Tory's Conservatives have signaled that they intend to join the manipulative campaign led by the for-profit health industry to privatize the health system for their own profits. Clearly Tory intends to use the provincial election campaign to try to force more health privatization," noted Natalie Mehra, coalition director.

"John Tory's persistence in forcing health care privatization will lead to unfair and costly two-tier

health care," she added. "The for-profit companies he is promoting are already charging user-fees and promoting two-tier care as a way to maximize their revenue and increase their profits. Tory's refusal to acknowledge the evidence that for-profit companies drive up costs and damage the public system is irresponsible."

"The rigorous meta-analyses of the same for-profit hospital services Tory is promoting shows that they not only cost more, but they are also lead to a higher rate of patient deaths as the companies cut corners to make room for profit-taking. Already, the fastest growing costs in Ontario's health system are produced

by the private for-profit sector. Health privatization is not innovation, in fact, it is the same old Harris agenda of ideological politics and polarization."

"We are prepared for a significant confrontation on the issue of health privatization through Ontario's provincial election campaign because protecting public and non-profit health services is so important to the future sustainability and fairness of the public health system," she concluded. ♦

Released by the Ontario Health Coalition May 24, 2007 to mark the PC release of its platform for the coming provincial election.

ONTARIO'S INCOME GAP AT ALL-TIME HIGH

Ontario's after-tax income gap between the richest and poorest 10% of families raising children under 18 has reached an all-time high, according to a new study released by the Canadian Centre for Policy Alternatives (CCPA).

The richest 10% of families now earn 75 times more than the poorest 10%. In 1976, they earned only 27 times more.

"The gap is growing during the best of economic times, in Ontario, one of the most prosperous jurisdictions in the world," says the study's author Armine Yalnizyan, research fellow for the CCPA. "Under these economic conditions, the gap should be shrinking, not growing.

"And this isn't just a story

about the richest and the poorest. More and more families are struggling to make ends meet. Living costs are rising far more quickly than many people's incomes."

Compared to a generation ago, the bottom 40% of Ontario families raising children under 18 have experienced stagnant or falling incomes, despite the past decade of robust economic growth and job creation. Ontario's after-tax income gap has been growing faster in the past decade than it has at any time in the past 30 years. The province's after-tax income gap is now higher than the Canadian average.

"Provinces with far less prosperity, and a higher earnings gap than Ontario, have done a better job of

closing the gap," says Yalnizyan. "Governments do make a real difference. The government of Ontario could be doing much more to close its growing after-tax income gap."

Governments have two ways of addressing the income gap, says Yalnizyan. One way is to implement measures to improve incomes; the second set of solutions focuses on making the basics of life more affordable (such as housing, child care, and postsecondary education). The report, Ontario's Growing Gap, is available at www.growinggap.ca and www.policyalternatives.ca. ♦

Released by the Canadian Centre for Policy Alternatives May 7, 2007

SAFER – IMPROVING WOMEN’S HEALTH IN THE DEMOCRATIC REPUBLIC OF THE CONGO

Brad MacIntosh and Cathy Nangini who spearheaded this very important campaign were interviewed by Anna-Maria Tremonti on the CBC radio program, *The Current*, on Thursday, June 21st, 2007—it should be accessible in the CBC archives at www.cbc.ca/thecurrent.

In 2004, students at the University of Toronto formed an organization called SAFER (Student Aid For the Elimination of Rape). The organization was created to bring attention to the plight of women in conflict-ridden countries, such as the Democratic Republic of the Congo, where rape is used as a weapon of war.

The student group flourished, advocating that the Canadian government develop a comprehensive plan to combat sexual violence in the DRC, and formed a partnership with a high-profile hospital in eastern DRC, in the city of Bukavu. The director of the Panzi Hospital, Dr. Denis Mukwege, has created a centre where women can be treated for the surgical and psychological effects of sexual violence. Between 2005 and 2006, SAFER was focused on meeting the immediate surgical needs that were in short supply.

After the first successful shipment of surgical wound care sutures for gynaecological procedures, SAFER received support from staff at Sunnybrook Hospital in Toronto.

The organization was no longer a student-based initiative and consequently the name changed to Social Aid For the Elimination of Rape, cleverly retaining the SAFER acronym!

The second major shipment of medical supplies took place in February - March 2007. But this time SAFER did more than ship thousands of dollars worth of equipment. Founder of SAFER, Dr. Cathy Nangini, assembled a research-team consisting of Drs. Brad MacIntosh, Naomi Matsuura and Olivier Couture.

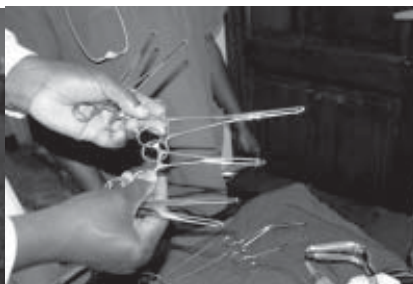
With ethics approval from Sunnybrook Hospital and guidance from expert epidemiologist Prof. Ross Upshur, the goal of this SAFER mission was to characterize the effects of sexual violence by reviewing the medical files for all rape survivors that were able to reach the Panzi Hospital for the year 2006.

Little is known about how to effectively build health capacity in complex humanitarian emergencies. The DRC is the worst humanitarian crises in modern day, with estimates at 3.9 million conflict-related deaths

between 1998 – 2004 (Coghlan et al, *Lancet*, 367: 44-41, 2006). Clearly, the health demands are immense.

SAFER is currently involved in two aspects that require assistance. First, we are in need of experience in obtaining registered charitable status. Second, SAFER continues to collect medical supplies at gratis that are specific to surgical care. SAFER does not accept perishable and disposable goods that are expired, but we do accept refurbished expensive items. A comprehensive list is available for those who are willing to volunteer or have access to medical supplies within your institution. ♦

This item was prepared by Brad and Cathy for distribution to potential contributors to their campaign, along with a wish list of items they are seeking for the Panzi Hospital. Keep an eye out for their report on their March 2007 trip to Africa and the results of their research project in our fall issue. For more information on the campaign, see www.medicalreform.ca or e-mail medicalreform@sympatico.ca



RESEARCH REQUEST

McMaster University researcher and long-time MRG member Dr. Gordon Guyatt is concerned about possible problematic marketing strategies that the pharmaceutical companies are using to spread the message encouraging the use of osteoporosis

drugs (mainly raloxifene and bisphosphonates) for the treatment of osteopenic women.

If you have any leaflets or other promotional material that the pharmaceutical representatives distributes about these drugs for their use in osteopenic women, he'd be

grateful for copies. Your samples or scanned copies thereof can be sent to him at guyatt@mcmaster.ca or to the CLARITY (Clinical Advancement through Research and Knowledge Translation) Team, NcMaster University, 1200 Main Street, West, Hamilton, Ontario L8N 3Z5 ♦

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
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- Free Medical Student / Medical Research Student

Please specify membership category:

Please specify areas of interest and expertise:

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Please charge my MasterCard/VISA in the amount \$ _____. My credit card account number is: _____
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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

READER EXCHANGE

An international reader has asked for an explanation of an item which appeared in our last issue, and we reprint both his note and a response solicited from Bob Biderman at Not Just Tourists Toronto, who provided the original article

In Medical Reform Vol 26 No 4, Spring 2007 [which] arrived to day, there is an article, "Not Just Tourists, Toronto." This refers to drug donations to Cuba.

I am surprised. Cuba is said to be a country with one of the best health care services with access to all. I cannot therefore understand the need for drug donations. Your comments please.

Best regards,

Dr K Balasubramaniam

Advisor and Coordinator

Health Action International Asia-Pacific 5, Level 2, Frankfurt Place
Colombo 4

I certainly understand Bala's confusion as to why a country with a reputation of having an excellent health care system with access to all

at virtually no cost to patients would need donations of medicines from abroad.

I am Canadian and clearly can't speak for Cubans, but I think that they would respond that the answer lies largely in the U.S. embargo. That embargo often makes it extremely difficult and expensive for Cuba to get many medicines and medical supplies. They now manufacture some of their own medicines and have also turned to using alternative medicines.

Nevertheless there are a great many items, some considered to be quite basic in Canada, which they do not have and are very appreciative of having donated. The eight autonomous Not Just Tourists groups across Canada are attempting to fill some of that need.

Medicines make up a relatively small percentage of what Not Just

Tourists Toronto sends. What we send is dependent on what is donated to us and we don't receive nearly as many meds as we'd like.

The bulk of our donations is comprised of medical supplies and small items of medical equipment - masks, gloves, catheters, syringes, kits (such as IV and wound care) that our nurses and volunteers have put together, and on and on. Those items are equally difficult to come by in Cuba and NJTT finds that growing quantities of that sort of thing are being donated to us. ♦

Bob Biderman, Co-ordinator

Not Just Tourists Toronto
www.njttoronto.ca

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

Please visit and comment on our web-site at <http://www.medicalreformgroup.ca>

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]