

Medical Reform

Newsletter of the Medical Reform Group

Issue 144

Volume 27, Number 4

Spring, 2008

OPERATIONALIZING HEALTH EQUITY: HOW ONTARIO'S HEALTH SERVICES CAN CONTRIBUTE TO REDUCING HEALTH DISPARITIES

Michael Rachlis, based on work for the Wellesley Institute – <http://wellesleyinstitute.com/>

Canada's Medicare system grew from a deep yearning for equal access to health care. Tommy Douglas suffered from osteomyelitis as a child in pre-World War One Winnipeg.¹ Just before his leg was amputated, a prominent surgeon offered to treat him with debridement for free if he agreed to be a teaching patient. Almost all Canadians knew those who went bankrupt paying family health care bills. Many suffered and died because they feared wracking up large debts as did one farmer with terminal cancer in Saskatchewan:

"This young woman refused to leave her home and as the disease progressed the pain was excruciating. When her husband went to work she had him lock the door, so no one could come in answer to her screams of pain. Her screaming and suffering lasted for two months, but she never gave in. Her whole being was dedicated to saving her husband and family the debt

of medical care that would have ruined him."²

Medicare made a tremendous difference in improving access to physicians and hospital services regardless of ability to pay. And, Canadians know deep in their hearts that no matter Medicare's woes, we took the right track when we veered off the path we were on with our American cousins fifty years ago. Despite the lies of Medicare's enemies, Medicare has been good to all Canadians, but especially to the poor and other disadvantaged groups. Health status

and health care access for vulnerable groups have both improved relative to the US since we implemented Medicare.^{3,4} However, we still have disparities in health and access to health care. This paper briefly outlines how the Ontario health sector could operationalize a health equity agenda.

Disparities in health

Of course, publicly funded health care does not eliminate disparities in health status. Poorer Canadian men are twice as likely to die within the first five years of their retirement as are richer men.⁵ Poorer women are 25 per cent more likely to die of heart attacks every year and poorer men are 35 per cent more likely to die of heart attacks each year.⁶ Aboriginal health is improving in Canada. But, aboriginal men and women still have life expectancies six and one-half years less than non-aboriginal Canadians.⁷

Disparities in health care

Despite over thirty years of universal coverage for physicians and hospital services in Ontario there re-

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**SPRING MEETING
THURSDAY, MAY 29, 2008
TORONTO**

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

Spring, 2008

Volume 27, No. 4 Issue 144

Medical Reform

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MEDICAL REFORM is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at \$60 per year. Arrangements may be made to purchase multiple copies or annual subscriptions.

Articles and letters on health-related issues are welcome--please forward electronically to medicalreform@sympatico.ca.

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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: Rosana Pellizzari, Gordon Guyatt, 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

Despite the earnest promises of our provincial government, it is clear that much remains to be done to ensure that more than lip service is paid to their election commitment to move forward on poverty reduction, to say nothing of poverty elimination in the near future.

The Medical Reform Group has joined more than 100 other community groups across the province in endorsing the call for clear targets, timetables and accountability with the objective of achieving a reduction of poverty in Ontario by 25 per cent in 5 years and 50 per cent in 10 years.

We also participated in a day of mobilization by the 25in5 in mid-April, and will continue to work with partners there to maintain the pressure on the province to improve on the down payment they made on this promise in the 2008 budget. For more information on some of our members' involvements in this campaign, see the websites at www.25in5.ca or www.healthprovidersagainstopoverty.ca. We also understand that the Ontario Medical Review and the Ontario Medical Association may be preparing to join the call for poverty reduction shortly.

In order to educate ourselves, we have two upcoming events for members.

On May 29th, Steering Committee members Arlene Bierman and Gary Bloch will summarize some of the work they have been doing on the poverty agenda over the past year or so, with a view to preparing members for a presentation at the already scheduled fall meeting.

At the second meeting, Assistant Deputy Minister of Health and Long Term Care will give a presentation and answer members' questions on the government's equity and access agenda.

Be sure to make a note now of the fall meeting date--Wednesday, September 17th at a location to be announced.

As promised in issue 143, an ad hoc committee of the Steering Committee has been reviewing our founding documents, constitution and bylaws, and in this issue, we have summarized changes which will also be dealt with at the May 29th members meeting. ♦

OPERATIONALIZING HEALTH EQUITY (continued from page 1)

main inequalities of access to these services. For example, in Ontario heart attack victims who are wealthier and better educated are more likely to receive specialized investigations, rehabilitation, and specialist follow up.⁸ Health care disparities are associated with education,^{9,10} race,^{11,12} gender,^{13,14} geography,^{15,16} reduced education,¹⁷ and lack of English proficiency. There is also some evidence that gay, lesbian, and transgendered Canadians face barriers to accessing health care services.^{18,19}

While Canada's system delivers more equitable care than the mainly privately funded US system, we in the middle range for countries with publicly funded systems.²⁰ As in most other countries with universal systems, lower income Canadians use less specialty care than their needs for care would predict. And, there are even greater disparities in access to those services for which there is not universal coverage, such as dental care.²¹

How can Ontario's Health Services reduce health disparities more effectively?

Disparities in health persist because certain groups are less resistant to illness because of their social and economic circumstances and because prevention is always more effective than the best treatment.^{22,23,24}

But, as the Canadian and US data show, effective affordable health care can reduce disparities. A recent Federal Provincial Territorial Health Disparities Task Group noted²⁵ that "The health sector has an important role to play in mitigating the causes and effects of other determinants of health through interventions with disadvantaged individuals, populations and communities."

The Ontario Health Quality Council identified equity as one of

its nine attributes of a high performing health care system in its first report in 2006:

"There should be continuing efforts to reduce disparities in the health of those groups who may be disadvantaged by social or economic status, age, gender, ethnicity, geography, or language."

This definition can be broadened further to include health disparities related to racism and discrimination, culture, citizenship status, sexual orientation, and ability. In their second report in 2007, the OHQC identified a three pronged approach to developing a more equitable system based on maximizing three of the other attributes:

1. Improving the **accessibility** of the health system through outreach, location, physical design, opening hours, and other policies.
2. Improving **patient-centredness** of the system by providing culturally competent care, interpretation services, and assisting patients and families surmount social and economic barriers to care.
3. Cooperating with other sectors to improve **population health**.

This section identifies examples of front line innovations which address health disparities.

Improving Accessibility

The OHQC defined accessibility as:

"People should be able to get the right care at the right time in the right time by the right health care provider."

The OHQC suggested that improving accessibility could enhance equity through outreach, location,

physical design, opening hours, and other policies.

CAISI strikes out inappropriate care for the homeless

In the Toronto Client Access to Integrated Services and Information (CAISI) Project, homeless persons give permission to a variety of agencies including shelters, drop in centres, outreach teams, hospitals, public health and Toronto ambulance, to link their electronic records using an enhancement of the OSCAR freeware McMaster system.²⁶ The health record is accessed through the internet so it allows multiple providers to communicate with each other about a very ill group of clients.

The CAISI project recently won the Canadian Information Productivity Silver Award for Not for Profit Efficiency and Operational Improvements.²⁷

Advanced Access opens doors to ambulatory care

Another example of innovation is the implementation of Advanced Access by some Community Health Centres and private practices. With Advanced Access, many primary health care practices find they can eliminate weeks long waits for care for routine appointments.²⁸ The Saskatoon Community Clinic implemented Advanced Access in 2004 and reduced the wait time to the third next available appointment²⁹ from 36 days for a complete physical and 8 days for a regular appointment to 2 days for both.³⁰ The Saskatoon Clinic has since been a leader in the Saskatchewan Health Quality Council's province-wide implementation of Advanced Access.³¹

Advanced Access increased practice capacity. Eventually, these

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OPERATIONALIZING HEALTH EQUITY (continued)

facilities achieved new equilibrium, but the new enrolments are significant, up to 500 patients per doctor. To quote Dr. Jeff Harries, a Penticton, B.C., family physician, “If every family doctor in the country went to advanced access, there would be no Canadian who didn’t have a family physician.”

Improving patient-centred care

The OHQC defined patient-centred care as:

“Health care providers should offer services in a way that is sensitive to an individual’s needs and preferences.”

The OHQC suggested that improving patient-centred care could enhance equity through providing culturally competent care, interpretation services, and assisting patients and families surmount social and economic barriers to care.

Access Alliance CHC Peers reach out to their communities

Toronto’s Access Alliance Community Health Centre Peer Outreach Worker Program greatly enhances health care access for new immigrant and refugees mothers and their children.³² The CHC uses neighbourhood ethno cultural networks and local and ethnic media to recruit and hire peer outreach workers who deliver 20 education programs. The outreach workers also facilitate well child and women clinics conducted by the CHC’s clinicians. Access Alliance has trained over one hundred peer outreach workers who have provided health care to over 10,000 women and their children while building community capacity.³³

Improving the effectiveness of the health system’s work with other sectors to achieve population health goals

Intersectoral action for health has been described by the World Health Organization as³⁴:

“A recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes, (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone.”

Complicated social problems require an intersectoral approach. Unfortunately, intersectoral action has proven much harder to fulfill in practice than to describe in theory.³⁵

The key barriers to effective intersectoral action addressing health disparities are:

- ◆ Not everyone places a high value on health.
- ◆ Information on the scientific relationship between a social determinant and health status is a weak factor for making policy.
- ◆ The key people interested in so-called healthy public policy come from the health sector. But the decisions about the social determinants of health are made in other sectors, e.g. housing, employment or by central agencies of government, e.g. cabinet office, department of finance.

There needs to be a four staged approach to promoting more effective intersectoral action for health. First, the health sector needs to engage communities to develop local projects. Second, successful local efforts must work their way up to policy makers in senior levels of

government. Third senior governments need to spread local policy and innovation. Finally, senior governments need to support community engagement.

Regent Park blazes a pathway to education

In the late 1990s, The Regent Park Community Health Centre identified education as the major determinant of the future health of neighbourhood children. In 2001, the health centre launched Pathways to Education with a number of partners. Pathways provides support for Regent Park children entering high school, including transit passes, tutoring, and mentoring. From September 2001 to present, the program has reduced the dropout rate from 56% to 10%.³⁶ The long-term economic benefit to society for every \$1 invested in Pathways is estimated to be \$12.

Provincial initiatives to support local action

Regent Park has successfully implemented Pathways to Education and it is starting to spread but for intersectoral action to succeed it needs to affect provincial and national level policy.

Saskatchewan

The Saskatoon Health Region has identified significant disparities in health and health care access within its catchment area.³⁷ For example, there are sixteen times as many suicide attempts in the poorest neighbourhoods than in the wealthiest, but only twice as many physician visits for mental health problems.

The Saskatoon Regional Intersectoral Committee is co-chaired by the Health Region’s vice-president for primary health care and the city’s director of parks and recreation. The committee includes representatives

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OPERATIONALIZING HEALTH EQUITY (continued)

from various provincial and federal government departments, municipalities, regional health authorities, housing authorities, educational institutions, tribal councils, police, and Métis organizations. All provincial and municipal governments and agencies have co-terminus boundaries.

Saskatchewan established the Human Services Integration Forum in 1994. It includes associate and assistant deputy ministers from eleven ministries and secretariats. The forum provides support to the Regional Intersectoral Councils and to a number of initiatives including Saskatchewan's Action Plan for Children, the Aboriginal Policy Framework, the Culture and Recreation Strategy, the Saskatchewan Training Strategy, and the Restorative Justice and Aboriginal Justice Strategies.

Quebec

Quebec has coordinated its social policy around a series of health goals since 1987. In 1998 Quebec passed two public health acts.³⁸ The legislation outlines a broad program of public health including "exerting a positive influence on major health determinants, in particular through trans-sectoral coordination."

The National Institute of Public Health is responsible for developing a provincial health plan based upon the province's health goals.³⁹ The Quebec regional health authorities are responsible for developing their own health plans which are consistent with the provincial plan. The CLSCs (Centres Locaux Services Communautaires), provide both public health and primary health care services. Under Quebec's public health legislation, the CLSCs are responsible for coordinating their local community's input into developing local public

health plans, congruent with the provincial and regional plans.

Conclusion

The implementation of Medicare greatly improved access to health care, particularly for poorer Canadians. But there are still persistent disparities in health status and access to health care. Governments need to develop broad intersectoral plans to remedy social disparities. But the health sector also needs to develop an operational plan for its own strategy to reduce health disparities. ♦

Endnotes

¹ Douglas TC. *The Making of a Socialist: The Recollections of TC Douglas*. Edited LH Thomas. The University of Alberta Press. 1982. Page 7.

² *Life Before Medicare: Canadian Experiences*. Ed. S. Charters. Ontario Coalition of Senior Citizens Organizations. Toronto. 1995:79.

³ James PD, Wilkins R, Detsky AS, et al. Avoidable mortality by neighbourhood income in Canada: 25 years after the establishment of universal health insurance. *Journal of Epidemiology and Community Health*. 2007;61:287-296.

⁴ Lasser KE, Himmelstein DU, Woolhandler S. Access to care, health status, and health disparities in the United States and Canada: Results of a cross-national population-based survey. *American Journal of Public Health*. 2006;96:1300-1307.

⁵ Wolfson M, Rowe G, Gentleman JF, Tomiak M. Career earnings and death, a longitudinal analysis of older Canadian men. *J Gerontol* 1993; 48(suppl):167-179.

⁶ Statistics Canada, Catalogue 82-003. Supplement to Health Reports, volume 13, 2002, p. 57.

⁷ Statistics Canada. Canada's Performance Report 2005 - Annex 3 - Indicators and Additional Information. Found at: http://www.tbs-sct.gc.ca/report/govrev/05/ann304_e.asp. Accessed: March 13, 2008.

⁸ Alter DA, Iron K, Austin PC, et al. Socio-economic status, service patterns, and perceptions of care among survivors of acute myocardial infarction in Canada. *Journal of*

the American Medical Association. 2004;291:1100-1107.

⁹ Croxford R, Friedberg J, Coyte P. Socioeconomic status and surgery in children: myringotomies and tonsillectomies in Ontario, Canada, 1996-2000. *Acta Paediatrica*. 2004; 93 (9): 1245-1250.

¹⁰ Language barriers in access to health care. Bowen S. Health Canada mimeo. November 2001. Found at: http://www.bc-sc.gc.ca/bcs-sss/pubs/care-soins/2001-lang-access/index_e.html. Accessed January 10, 2005.

¹¹ Halwani S. Racial Inequality in Access to Health Care Services. A paper for the Ontario Human Rights Commission. 2002. Found at: <http://www.ohrc.on.ca/english/consultations/race-policy-dialogue-paper-sh.pdf> accessed 060226

¹² Kafele K. Racial Discrimination and Mental Health: Racialized and Aboriginal Communities. A paper for the Ontario Human Rights Commission. 2002. Found at: <http://www.ohrc.on.ca/english/consultations/race-policy-dialogue-paper-kk.shtml> accessed 060226.

¹³ Tu K, Mamdani MM, Hux JE et al. Progressive trends in the prevalence of benzodiazepine prescribing in older people in Ontario, Canada. *Journal of the American Geriatrics Society*. 2001;49:1341-1345.

¹⁴ Slaughter PM, Bondy SJ. Difference in access to care. In: Canadian Cardiovascular Society 2000 Consensus Conference; women and Ischemic Heart Disease. 2000;17(supplD):63D-67D.

¹⁵ Woodward G, van Walraven C, Hux JE. Utilization and outcomes of HgbA_{1c} testing: a population-based study. *Canadian Medical Association Journal*. 2006;174:327-329.

¹⁶ Haider A, Mamdani M, Shaw J, et al. Socio-economic status influences care of patients with acne in Ontario, Canada. *Journal of the American Academy of Dermatology*. 2006; 54 (2): 331-335.

¹⁷ Rhodes A, Jaakkimainen L, Bondy S, Fung K. Depression and mental health visits to physicians: a prospective, records-based study. *Social Science and Medicine*. 2006; 62 (4): 828-834.

¹⁸ Brotman S, Ryan B, Jalbert Y, et al. The impact of coming out on health and health care access: the experiences of gay, lesbian, bisexual, and two spirit people. *Journal of Health and Social Policy*. 2002;15:1-29.

(continued on page 6)

OPERATIONALIZING HEALTH EQUITY (continued)

- ¹⁹ Bowen DJ, Bradford JB, Powers D, et al. *Comparing women of differing sexual orientations using population-based sampling*. *Women and Health*. 2004;40:19-34.
- ²⁰ Van Doorslaer E, Masseria C, Koolman X, et al. *Inequalities in access to medical care by income in developed countries*. *Canadian Medical Association Journal*. 2006;174:177-183.
- ²¹ Lawrence HP, Leake JL. *The US Surgeon Generals Report on Oral Health in America: A Canadian perspective*. *Journal of the Canadian Dental Association*. 2001;67:587-595.
- ²² "A population health strategy focuses on factors that enhance the health and well-being of the overall population. It views health as an asset that is a resource for everyday living, not simply the absence of disease. Population health concerns itself with the living and working conditions that enable and support people in making healthy choices, and the services that promote and maintain health." From Federal Provincial Territorial Advisory Committee on Population Health. *Strategies for Population Health: Investing in the Health of Canadians*. 1994.
- ²³ Lalonde M. *A New Perspective on the Health of Canadians*. Ministry of Supply and Services 1974. Found at: <http://www.phac-aspc.gc.ca/ph-sp/phdd/pdf/perspective.pdf>. Accessed November 4, 2005.
- ²⁴ Epp J. *Achieving Health for All: A framework for Health Promotion*. Released at First International conference on Health Promotion. Ottawa. 1986. Found at: http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-frame-plan-promotion/index_e.html. Accessed September 7, 2006.
- ²⁵ Health Disparities Task Group of the Federal Provincial Territorial Advisory Committee on Population Health and Health Security. *Health Disparities: Roles of the Health Sector*. 2004. Found at: http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf. Accessed September 23, 2006.
- ²⁶ See: <http://www.oscarmcmaster.org/>. Accessed April 22, 2008
- ²⁷ See: <http://www.cipa.ca/>. Accessed November 20, 2007.
- ²⁸ Murray M, Berwick DM. *Advanced access: reducing waiting and delays in primary care*. *Journal of the American Medical Association*, 2003;289:1035-1040; Murray M, Bodenheimer T, Rittenhouse D, et al., *Improving timely access to primary care: case studies of the advanced access model*. *Journal of the American Medical Association*, 2003;289:1042-1046.
- ²⁹ See: <http://www.saskatooncommunityclinic.ca/special-programs.htm#Advanced%20or%20Improved%20Access>. Accessed April 22, 2008.
- ³⁰ See: <http://www.hqc.sk.ca/portal.jsp?YCH29-pwj+D3REByy7z2dijBlzBf0QfLQkUw-K4QBZaIvwO9ghh5dfuYzOVcA+lmY4>. Accessed April 22, 2008.
- ³¹ See: <http://www.accessalliance.ca/>
- ³² Personal communication with Sonja Nerad. Toronto. June 7, 2006.
- ³³ WHO International Conference on Intersectoral Action for Health 1997. Halifax.
- ³⁴ Fortin J-P, Groleau G, Lemieux V, O'Neill M, Lamarche P. *Intersectoral Action for Health*. Laval University. mimeo. 1994.
- ³⁵ See: <http://pathwaystoeducation.ca/results.html>.
- ³⁶ M. Lemura, C. Neundorff, and J. Opondo, "Health disparities by neighbourhood income," *Canadian Journal of Public Health* 97 (2006): 435-9.
- ³⁷ *Quebec Public Health Act*. (Updated September 1, 2003) http://publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_2_2/S2_2_A.html accessed 030926. *National Institute of Public Health Act* http://publications-duquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/I_13_1_1/I13_1_1_A.html accessed 030926.
- ³⁸ *Quebec Public Health Act* (updated 1 September 2003) http://publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_2_2/S2_2_A.html (accessed 26 September 2003); *National Institute of Public Health Act* http://publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/I_13_1_1/I13_1_1_A.html (accessed 26 September 2003).
- ³⁹ *Quebec Public Health Act* (updated 1 September 2003) http://publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_2_2/S2_2_A.html (accessed 26 September 2003); *National Institute of Public Health Act* http://publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/I_13_1_1/I13_1_1_A.html (accessed 26 September 2003).

REVIEWING THE DOCTOR-PATIENT RELATIONSHIP

Steering Committee member Irfan Dhalla wrote the College of Physicians and Surgeons of Ontario on February 15th, 2008 on our behalf to underscore our support for a proposed policy revision to monitor acceptance of patients with greater than average needs. Look for final statement from the college on this issue by early summer.

Ms. Sharon Vanin
College of Physicians and Surgeons of Ontario
80 College Street
Toronto, ON M5G 2E2

Dear Ms. Vanin:

Re: Input into the 'Establishing a Physician-Patient Relationship' Policy

We are writing in response to the CPSO's request for comments on its proposed policy regarding the establishment of a physician-patient relationship.

We are broadly supportive of the proposed policy and its various elements. In general, we believe it strikes an appropriate balance between patient and physician needs. Furthermore, the proposed policy is fair and will be useful to both physicians and members of the public.

This policy is especially important in light of the ongoing physician shortage. We too have heard reports of physicians turning away patients for inappropriate reasons. This practice has become so entrenched that one of our newer members, when nearing graduation from her family medicine residency program a few years ago, was advised at an educational session devoted to practice management that physicians should reject patients who were unable to speak English, even if the services of a translator were available!

We would like to particularly commend the CPSO for stating that patients should not be charged for initial interviews. Charging for initial interviews could pose a significant barrier for many patients.

We do have one suggestion, regarding the paragraph:

"It is always appropriate for a physician to decline to accept a patient when the physician does not have the clinical competence to meet the patient's existing health care needs." (page 3, lines 88-90).

In many cases it may be appropriate for a family physician to accept a patient even if they do not have the clinical competence to meet all of that patient's health care needs. This is because a major role for family physicians is to serve as a co-ordinator of care for patients with complex diseases. For example, a patient with rheumatoid arthritis, coronary artery disease and depression (not a particularly rare triad) might be under the care of a rheumatologist, an orthopaedic surgeon, a cardiologist and a psychiatrist. Although no family physician would be expected to meet all of this patient's needs, his or her family physician could reasonably be expected to reconcile recommendations from the various specialists and ensure that periodic health exams were being recommended as appropriate. We therefore suggest the CPSO consider amending this paragraph.

We recognize that your proposed policy has generated considerable opposition from other physician groups. We believe that this opposition is misplaced, and are convinced that the establishment of this policy would serve Ontarians well.

Please feel free to contact us if we can be of further assistance. ♦

TOUGHER REGULATION NEEDED FOR DRUG INDUSTRY

The edition of JAMA, the largest circulation medical journal, released yesterday afternoon included two articles that highlight the grave problems with the profit motive in health care.

Both articles were based on documents made public during litigation against one of the largest drug manufacturers, Merck & Co Inc. The first article documented Merck's extensive practice of using ghost written articles. Merck would hire writers to produce articles favourable to their product. They would then recruit prestigious academics, and pay them to put their names on the paper, often as first or second authors. The true writer's name would not appear or be acknowledged.

The second article revealed how Merck had suppressed results that showed an increased death rate

with use of one of their drugs in patients with Alzheimer's disease.

"These are the latest in a series of revelations of how the pharmaceutical industry's focus on profit works against the public interest," said MRG spokesperson Ahmed Bayoumi. "Of all the problem practices, the worst is the suppression or distortion of evidence. The industry hides adverse effects of their drugs, and releases information to make drugs appear better than they actually are."

One recent revelation demonstrated how the industry selectively released studies looking at the effectiveness of antidepressants to make their beneficial effects appear much greater than the true effect. Another showed how the industry suppressed results to hide increased suicide rates

in adolescents given antidepressant drugs.

"Let's be clear," said another MRG spokesperson, Dr. Gordon Guyatt. "The problem isn't the evil pharmaceutical industry. They are behaving as one would expect given their primary goal, which is to maximize profits for their shareholders. The problem is how the profit motive plays out in health care."

"The only solution is tougher regulation of the industry," Dr. Bayoumi concluded. "The rules have to change: we need legislation that requires industry to make public the results of all their studies. There is also a deeper message: when we can keep the profit motive out of health care, we must do so. Our patients' well-being demands it. ♦"

Released by the Medical Reform Group April 16, 2008.

STUDENT CHAPTER AT UNIVERSITY OF WESTERN ONTARIO

Hats off to Iva Vukin and Farh Manji, co-founders and co-chairs of one of the most active student Medical Reform Group chapters

Our **MRG speaker series** was an amazing success, drawing large crowds at each event and setting a precedent for both caliber and attendance at medical student-run events at UWO.

The series kicked off with Dr. Danielle Martin's talk, *Health care financing and delivery in Canada: Examining the evidence*, on October 1, 2007. Over one hundred medical students and faculty applauded Dr. Martin for her outstanding explanation of Canada's health care system.

In November, Dr. Ahmed Bayoumi gave a well-received talk on

the importance of maintaining Medicare in Canada as a basic means of social justice. Students and faculty alike were impressed with the knowledge and passion that Dr. Bayoumi imbued.

On January 9, 2008, Dr. Joel Lexchin rang in the spring term with his talk, *Pharmacare: Canada has been waiting too long*, exposing naïve students to an important and emerging idea in Canadian health care.

On March 4, 2008, Dr. Gordon Guyatt gave a riveting talk entitled *Why bother with evidence-based medicine*, which students and faculty flocked to

in droves. The final talk in our speaker series is set for April 10, 2008, featuring our former Dean of Medicine, Dr. Robert McMurtry.

Dr. McMurtry will be discussing the social determinants and their implications on our current health care system in his talk entitled *Convenient Fictions*.

In addition to the speaker series, we have been most recently involved in rebuking the condemning article *Adding fuel to the doctor shortage*, featured in Maclean's magazine on January 14, 2008. In short, the piece

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STUDENTS CRY FOUL ON DOCTOR SHORTAGE

Iva Vukin and Farah Manji never expected to be blamed for Canada's doctor shortage.

"It was a shock . . . it is scapegoating females," said Vukin, a second-year medical student at the Schulich School of Medicine and Dentistry at the University of Western Ontario.

The jump in female medical students to more than half of current enrolment is being pinpointed as a reason for the growing shortage of family doctors and specialists.

Commentators, including Dr. Brian Day, president of the Canadian Medical Association, have said it's clear female doctors won't work the same hours or have the same lifespan of contributions to the medical system as males.

The most recent broadside came in a Maclean's magazine article that described the frustration patients face when female doctors shut down their practices to spend more time with families.

Vukin and Manji say it is unfair to blame women for the doctor shortage.

All medical students, not just females, are looking to balance their personal and professional lives, they say.

"There is no longer that view that you have to be married to your job when you are a doctor, that you are married to medicine and you spend all of your time in the hospital or with your patients while your personal life crumbles," Manji said.

Vukin said it is a shock to see female doctors being blamed for shortages instead of earlier policies that limited medical school enrolment.

The issue has also sparked outrage from the deans of medical schools at Western and the University of Toronto.

In a joint response to the Maclean's article, Dr. Carol Herbert of Western and Dr. Catharine Whiteside of the University of Toronto write that suggesting women aren't working hard enough is alarmist and unfair.

"Yes, women do work differently than their male counterparts.

Women spend more time on their combined professional, family and household responsibilities than their male counterparts," said the letter to the editor also signed by Dr. Barbara Lent, associate medical dean at Western, and Dr. Sarita Verma, vice dean, and Dr. Lynn Wilson, chairperson of the department of family and community medicine at the University of Toronto.

The deans wrote that preventing burnout in health care is crucial. "We believe that paying attention to personal and family responsibilities is a good thing for all doctors, male and female, their families and ultimately their patients."

Vukin said being singled out as a big part of the doctor shortage problem was jolting because she has never faced any discrimination from her colleagues at medical school.

"We all treat each other equally," she said. ♦

Article by John Miner for Sun Media, February 22, 2008

STUDENT CHAPTER AT UNIVERSITY OF WESTERN ONTARIO (continued)

accused female physicians for significantly contributing to Canada's physician resource crisis because they work fewer hours than their male counterparts. To date, we have been featured in the *London Free Press* article *Students cry foul on doctor shortage* (<http://lfpres.ca/newsstand/CityandRegion/2008/02/22/pf-4867365.html>), to which Dr. Brian Day promptly responded. On Feb-

ruary 28, 2008, we participated in a *Newstalk 1290* radio interview.

We would like to take this opportunity to thank everyone who has supported and guided us over the past year. Our success could not have happened without your help. We would especially like to thank our speakers, who so generously donated their time to impart their wisdom and passion on our students and faculty. ♦

MEDICAL REFORM GROUP DECRIES EXCLUSION OF NON-FOR-PROFIT PROVIDERS FROM HOME CARE BIDDING

We followed up our media release of January 17th with an urgent letter to the Minister of Health and the Premier seeking a stop to the competitive bidding process. The Minister responded noting that they had suspended the process for all new pending a review which has yet to report.

Hamilton CCAC has decided that the Victorian Order of Nurses and St. Joseph's Health Care, the largest not-for-profit agencies in the region, are not eligible in a "competitive bidding" process to submit requests for proposals to provide home care services in Hamilton.

"The decision," said MRG spokesperson Dr. Shelly Sender, "is the latest demonstration that the competitive bidding process is a catastrophe".

The process has been a disaster for home care workers who have suffered a loss of job security unique in the health sector. "Demoralized, alienated workers do not deliver optimal quality health care" commented

another MRG spokesperson, Dr. Ahmed Bayoumi.

"The process has been a disaster for primary care physicians," said Dr. Sender, who works as a family physician in Hamilton. "Family doctors have lost the effective partnership with home care workers in managing their frail elderly patients. The home care workers who see patients are less accessible - or inaccessible - for co-operative patient management."

The biggest disaster is deterioration of care for home care recipients. "Loss of continuity, and decreased patient-oriented care mean a major loss of support for the most vulnerable members of our community," said Dr. Bayoumi.

The deterioration in quality of care is consistent with other evidence regarding for-profit versus not-for-profit health care provision. For-profit hospitals and dialysis facilities have higher death rates than not-for-profit facilities.

"When dollars that should be going to health care go to profit," Dr. Sender concluded, "providers cut corners and patients suffer. The McGuinty government has established rules that benefit for-profit providers while hurting dedicated health workers, concerned physicians, and the vulnerable elderly." ♦

Released by the Medical Reform Group January 17, 2007

Dear Minister Smitherman and Premier McGuinty,

I am writing on behalf of the Medical Reform Group to commend you for your decision to stop the competitive bidding process for home care nursing services in Hamilton.

We believe the current competitive bidding process is flawed. In addition to disrupting continuity of care and caregiver, and demoralizing the health workforce, the legislation instituted by the previous government compromises the accountability much of your government's policy-making has been designed to encourage.

We therefore urge you to place an indefinite moratorium on competitive bidding for home care services across Ontario.

Sincerely,

[original signed by]

Ahmed Bayoumi MD, FRCPC

cc. Ontario Medical Association

Canadian Doctors for Medicare

Registered Nurses Association of Ontario ♦

MEDICAL REFORM GROUP: CMA USING AN AXE INSTEAD OF A SCALPEL

The MRG of Ontario commends Brian Day and the Canadian Medical Association for raising the issues of wait times and doctor shortages but chides the doctors' organization for not aggressively advocating the public sector solutions that will keep Medicare on course.

"Brian Day is an excellent surgeon," said MRG spokesperson Ahmed Bayoumi, "but when it comes to health policy he wants to operate with an axe rather than a scalpel."

In a document released yesterday, the CMA pointed out the looming increase in the shortage of

doctors, and called for a massive increase in training.

"Yes, we need to train more doctors," said another MRG spokesperson, Dr. Shelley Sender. "But we also need to get serious about transforming primary health care toward a multidisciplinary model of care. Increased reliance on nurse practitioners, for instance, could be an option."

In a second document, the CMA pointed to the economic cost of patients waiting for elective procedures.

"Of course, waiting lists are a problem. But the report repeatedly mentions the Chaoulli decision. Is this more of Brian Day pushing for-profit delivery as a solution when

public sector remedies are what are really needed?" Dr. Bayoumi questioned.

"What would be really welcome is for the CMA to push hard for more of the innovations that would effectively address wait lists while maintaining equitable health care for all Canadians" Dr. Bayoumi concluded. "That would include targeted funding for developing a national information technology system, not-for-profit dedicated outpatient surgical facilities, and national Pharmacare and national home care programs."♦

Released by the Medical Reform Group January 16, 2008

CASTONGUAY REPORT: IDEOLOGY, SELF-INTEREST TRUMPS EVIDENCE, PUBLIC GOOD

Claude Castonguay's recommendations for Quebec health care are just what one would expect from an insurance company executive," Medical Reform group spokesperson Ahmed Bayoumi said today. "Were Castonguay's recommendations adopted, the beneficiaries would be the rich, physicians, and insurance companies. The losers would be the general public."

Castonguay's recommendations include a greater role for for-profit providers in health care delivery in Quebec, allowing doctors to practice in public-pay and private-pay settings, payments from patients according to their use of services, and provision for private insurance for publicly insured services.

"The evidence is overwhelming that for-profit care is lower quality and leads to worse health outcomes," said Dr. Bayoumi. "Results have included higher death rates in hospitals and dialysis facilities, and poorer nursing home care."

"Allowing doctors to practice in both systems is a recipe for deteriorating care in publicly funded institutions and a worsening of the existing shortage of doctors," Dr. Bayoumi continued.

Studies of American health care have highlighted the inefficiencies of private insurance. Insurance companies have costs associated with creating packages, assessing eligibility, processing claims, and delivering a profit to shareholders. Universal public insurance has none of these costs.

"The U.S. spends 32 per cent of its health care dollars on administration, and Canada 17 per cent. Private insurance is responsible for the American inefficiency," Dr. Bayoumi noted. "Mr. Castonguay's ties to the insurance industry offer the best explanation for his making a suggestion that would be truly catastrophic for Quebec health care."

"Castonguay gives away his underlying philosophy in his comments," Dr. Bayoumi concluded. "Castonguay thinks that health care should be treated the same way as purchasing an automobile, a house, or clothing. Canadians know that health care is different, and that we should ensure high quality for all. It's a pity that Castonguay's panel does not."♦

Released by Medical Reform Group February 20, 2008

P3 (PUBLIC-PRIVATE PARTNERSHIP) HOSPITALS: WHAT CAN WE LEARN FROM OTHERS

Norman Kalant

The development and features of P3 hospitals in Canada can best be understood as a derivation from the development in the UK, where P3 hospitals evolved as a specific form of Private Finance Initiative.

The Private Finance Initiative in the UK

In the early post-war years, social support programs were developed in many fields (health, education, housing and the like) by Labor governments, for ideological reasons and to bring the UK into line with the more highly industrialized countries of Europe. However following its election in 1979, the Conservative government began a deliberate shift away from public sector to private sector control of social activities.

Initially this consisted of contracting out to the private sector the service activities requiring low skill levels (cleaning, dietary, laundry) but soon was expanded to include the financing of major construction projects, to be used for public sector purposes (the so-called Private Finance Initiative or PFI).

Traditionally the central government and local authorities built roads, schools, hospitals and other infrastructure by determining the specifications of the new structure, inviting tenders from private contractors, and negotiating a time-line for construction and the details of payment. Funds to cover the costs of construction were obtained from tax revenues or by borrowing money from commercial sources. The com-

pleted structure is an asset owned outright by the community.

Under a PFI scheme the contractor, usually a financial consortium, raises the funds privately to cover costs of construction and of borrowing capital. These funds are recovered from the community by a long-term leasing arrangement with the rent paid by the community to the contractor. In the case of hospitals the lease includes an agreement that the contractor becomes the provider for some of the non-clinical services.

Initially the major reason for private financing was to avoid controls on public expenditure. This maneuver was blocked by the "Ryrie Rules" (1981) which stated that a project could be privately financed only if this gave better value for money than public finance and that the cost should still be counted within the public capital budget. Since these rules discouraged private investment they were rescinded (1989) and the PFI was promoted. At the same time there was increasing regulation of the procedure to be followed and of the specificity of the contract.

In the case of new hospital construction the stepwise procedure is:

1. The hospital trust prepares a "business case" which announces that private financing will be sought;
2. The National Health Service is asked to approve the case presentation;
3. The trust issues invitations to selected consortia to negotiate construction of a hospital capable of

supporting a specified level of clinical activity.

It is important to note that the measure of output is clinical activity, a criterion conceptually related to the number of beds, patient turnover, length of stay etc. but which remains undefined. The conversion of number of beds originally planned to a level of clinical activity is negotiated by the hospital trust and the building consortium. It is not essential, nor even common practice to consult the medical staff of the new hospital on this matter.

4. When the conditions of the partnership have been settled, the hospital trust consults the Community Health Council. The various forms of partnership for hospital provision are DBFO (design, build, finance, operate), BOO (build, own, operate), BOOT (build, own, operate, transfer) and other possible combinations of the basic components.

In the UK the commonest model of P3 has been the DBFO. Since the government made no money available for the traditional public funding all hospitals were of necessity financed privately. Much of the funding was "off-balance-sheet" and did not appear in the government records as new borrowing.

5. The Labor government elected in 1997 introduced the concept of Public Private Partnership which entailed partial or full privatization, and partnership with private sector firms to sell government serv-

P3 (PUBLIC-PRIVATE PARTNERSHIP) HOSPITALS: WHAT CAN WE LEARN FROM OTHERS (continued)

ices. In comparing the budgeted cost of the project by traditional and by P3 financing the applicant is required to use a cost of 6 per cent for public sector capital thus giving a falsely elevated estimate of the cost of traditional financing.

The ideological goal of this situation was to shift healthcare delivery out of the public sector on the assumption that the public sector is less efficient and responsive than the private sector. The outcome however was a financial disaster in many of the projects, with costs far above those associated with traditional processes.

A detailed review of a sampling of the first wave of hospitals built on the DBFO model showed the following:

- ◆ **Cost:** The average cost over-run was 72 per cent of the original proposal. A major factor in this was the high cost of financing—22 per cent of the construction costs. The cost of borrowing was 9.9 per cent compared to the traditional cost of 3-3.5 per cent for government borrowing.

- ◆ **Facilities Provided:** The number of beds in the finished project was 7-44 per cent (average, 27 per cent) lower than the number originally considered necessary to meet the needs of the community to be served by the new hospital. In some cases whole buildings were dropped from the plans. These results have been summarized as “the community is paying more for less”. At the same time the profit accruing to the investors was of the order of 9-18 per cent, compared to a gen-

eral industrial average in the order of 5 per cent.

Proponents of the P3 concept claim that more of the P3 hospitals than of the public projects were completed on time and on budget. This cannot be proven since no hospitals are financed in the public sector. Furthermore these claims, even if true, have in numerous cases been achieved by shoddy or sloppy construction. Of great concern is the fact that the negotiations on design, construction and cost are carried out in secret so that the community does not always know the original plan for bed number, cost, etc., and has no way of knowing what changes were made during construction.

Supporters of P3 have offered many different explanations for the problems encountered, but it seems all of them can be readily explained by the profit motive which drives the private “partner”. The investors consider their negotiations and planning as confidential and therefore closed to public scrutiny.

During the design phase, it is in their interest to press for changes that will increase the total cost of the project, other changes which may reduce “cut corners” on construction materials without commensurate lowering of the budget and to reduce the size and complexity of the building as reflected in the number of beds. It is also in their interest to raise the amount of capital borrowed, the cost of borrowing and the duration of the “lease-back” when negotiating the financing arrangements.

The problems extend into the services provided by the private partner when the hospital opens its doors. Profit maximization leads to lowering of costs by reducing services, cutting corners etc. A systematic review of studies comparing the quality of care provided by for-profit and not-for-profit inpatient care providers showed that the latter had superior performance on access, quality, cost, and amount of non-insured care.

P3 Hospitals in Ontario

Although many observers in the UK consider the PFI and the P3 efforts to be a disaster for the NHS, this has not prevented other jurisdictions from copying the UK model. Ontario is one of these. Two hospitals have recently been “completed”, using the DBFO model; despite repeated reassurances from provincial politicians and spokespersons for the private partner that everything was going according to plan, it was only when all relevant documents were obtained under the access to information act that the multiplicity and magnitude of the problems became known. In addition, as of March 2006, official announcements of hospital privatization had been made for almost 30 other sites.

Some of the features of the construction of the Brampton Civic Hospital are given in Figure 1 and these results are compared to those found in the UK in Figure 2 which follows.

P3 (PUBLIC-PRIVATE PARTNERSHIP) HOSPITALS: WHAT CAN WE LEARN FROM OTHERS (continued)

Figure 1. Features of the Construction of the Brampton Civic Hospital

	Original Plan	Final Delivery
Construction Start	November, 2001	--
Construction Mandate	New Building + renovate Grace Hospital	--
Number of Beds	608	479
Cost	\$350m	\$650m
Proposed Opening Date	October 2005	October, 2007
	Grace Hospital renovation	Grace Hospital Phase scrapped

Profit: Investment \$61m; Returns \$61m + \$260m = 40 per cent of final cost)

Subsidies were received by the private partner in the form of \$114m from the government of Ontario “to make sure that the opening was on time” and several millions in voluntary donations from the community. It is not clear how these latter funds were accounted for.

Figure 2. Comparison of some Features of the P3 Hospitals in UK and Ontario

Category	UK	Brampton	Brampton
Cost Overrun	72%	86%	25%
Beds (percentage of original plan)	73%	79%	
Operating Room (percentage of original plan)		60%	
Delay in completion		2 years	

Unlike the UK, Ontario has no regulations governing P3 contracts; the public partner should have been able to learn from the UK experience and negotiate from a position of knowledge. Partnerships and alliances work when the participants

have a common goal. That of the elected government should be to improve the lot of the citizens as a whole; that of private enterprise is to maximize the benefit to the entrepreneurs and shareholders at the expense of the rest of society.

It is clear that the government learned nothing from the experience of others, or is determined for ideological reasons to destroy the public, not-for-profit hospital system. ♦

MEDICAL REFORM GROUP BYLAW PROPOSED BY-LAW AMENDMENTS

*In our winter issue, we summarized the work of an ad hoc bylaw review committee which prepared the following package of materials which integrate the proposed amendments. As noted in the winter 2008 issue of **MEDICAL REFORM**, our constitution obliges us to give 30 days notice of amendments, which we expect to deal with at our spring members' meeting, Thursday, May 29th, 2008. In brief, in addition to some modernization of our statement of principles, the main import of the amendments is to: 1] eliminate the requirement for a fall semi-annual meeting; 2] reconstitute the Steering Committee; and 3] call for the design of a plan for electronic polling on issues of concern to members. For more information, please contact the office as noted.*

STATEMENT OF PRINCIPLES

As physicians and medical students, we recognize that illness and health have physiological causes as well as social, economic, occupational, and environmental ones. As such, addressing social inequities is important to improve and preserve health, both because such inequities can be a direct contributor to ill health and also because effective methods to improve health require attention to the social context in which such interventions are applied. Accordingly, our focus is on the fight for social justice from the perspective of physicians. In this context, we are dedicated to:

- ◆ addressing social inequities, particularly focusing on the social determinants of health and the resultant health effects
- ◆ eliminating disparities in health within the broader context of the struggle against social disparities
- ◆ promoting practices and policies that contribute to equity in access to health care resources and services

Consistent with these principles, we strongly support the Canada Health Act and the publicly funded and delivered health care system developed on the basis of the Act. We are deeply concerned with the attacks on the principles of universality and the introduction of profiteering in health care insurance and delivery.

The purpose of this organization is therefore twofold:

“to provide a forum for discussion of current Canadian health issues and to present our views to the public at large

“to address the social issues affecting health and healthcare in Canada and to advocate for appropriate changes

We see many areas where social change is needed to improve health, including increased attention to the roots of illness in Canada, a growing need to democratize the health care system, and a shift in physician thinking such that we will be in the forefront of the struggle to uphold the principle that health care is the right of all Canadians.

We recognize that these concerns extend beyond immediate issues, and that in seeking change, we must examine the intellectual, social, political, and economic underpinnings of the prevailing philosophy of medicine, particularly those which transform health care into a saleable commodity.

In our efforts to meet these goals, we shall recognize the priority 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 mon-

etary or other deterrent to equal care.

2. **Health is political and social 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.

The Medical Reform Group is committed to solidarity work in these pursuits with other health care workers and social justice organizations. The Medical Reform Group is not affiliated with any political party; our common base is our commitment to the above principles.

1. This organization shall be known as the Medical Reform Group of Ontario, or the MRG.

MEMBERSHIP

2. Full membership in the Medical Reform Group of Ontario is open to graduate physicians or medical

(continued on page 16)

MEDICAL REFORM GROUP BYLAW PROPOSED BYLAW AMENDMENTS (continued)

students living or working in the province of Ontario who are in agreement with the statement of principles of the organization.

3. Affiliate membership in the Medical Reform Group of Ontario is open to physicians and medical students living or working in other provinces who are in agreement with the statement of principles.

4. Associate membership in the Medical Reform Group of Ontario is open to other health care workers and interested consumers who reside in Canada and are in agreement with the statement of principles.

5. Full members may attend all meetings of the Medical Reform Group, may hold office in the organization, and shall have one vote at General Membership meetings and receive all mailed ballots. They will receive all mailings of the Medical Reform Group of Ontario.

6. Affiliate members will receive all mailings of the MRG may attend all meetings but will not be counted for purposes of determining a quorum at any meeting of the Medical Reform Group of Ontario.

7. Associate members will receive all mailings of the MRG and may attend all meetings of the MRG as non-voting observers.

8. Membership fees shall be as established by a General Membership meeting and shall be reviewed annually.

9. Criteria for membership shall be reviewed when deemed necessary.

ORGANIZATION

A. Provincial Steering Committee

10. At the provincial level, there shall be struck a Provincial Steering Committee. The Steering Committee shall be comprised of a minimum of seven members, including at least one student. The normal term of office shall be 3 years.

11. Nominations for the Provincial Steering Committee shall be subject to approval by a General Membership meeting. Between General Membership meetings, additional Steering Committee members may be recruited following endorsement by existing Steering Committee members.

12. The Provincial Steering Committee shall meet at least four times a year. A quorum shall consist of a simple majority of the total membership of the Steering Committee. All meetings of the Steering Committee shall be open to any member of the MRG, and minutes will be posted to the Steering Committee electronic list following approval by the Steering Committee. Provision will be made for polling members electronically where necessary.

13. The Provincial Steering Committee shall be responsible for:

a) Implementation of policies adopted by the Membership

b) Approval and release of all public statements and other representations made in the name of the provincial Medical Reform Group

c) Co-ordination of the activities of Ad Hoc Working Groups at the provincial level

d) Co-ordination and correspondence with affiliate members

or with similar organizations outside Ontario

e) Allocation of financial and other resources of the provincial organization

f) Publication of a provincial newsletter at least four times a year

g) Any other such duties as may be directed by a General Membership meeting.

14. The Steering Committee shall elect from its members a Secretary Treasurer and whatever other officers it deems necessary to properly carry out its functions.

15. The Steering Committee may establish and supervise committees to assist it in its administrative duties, subject to approval by the next General Membership meeting.

16. The Steering Committee shall be authorized to formulate policy and to act on behalf of the membership of the Medical Reform Group. Any such action must be approved by a simple majority of members of the Steering Committee. Any action so taken shall be communicated to the General Membership in the next regular newsletter.

17. The Steering Committee may seek the resignation from the Steering Committee of any member who misses three consecutive Steering Committee meetings without reasonable cause.

B. Ad Hoc Working Groups

18. Ad Hoc Working Groups may be established by any member or members of the Medical Reform Group, subject to the approval of the Steering Committee.

(continued on page 17)

MEDICAL REFORM GROUP BYLAW PROPOSED BYLAW AMENDMENTS (continued)

19. Each Ad Hoc Working Group shall establish its own procedures for operation and shall submit regular reports to the Steering Committee and the general membership.

20. In addition to its other activities, an Ad Hoc Working Group may draft policy statements on topics within its sphere of interest for discussion and adoption by the general membership.

MEETINGS

21. A General Membership meeting shall be defined as a meeting of full, affiliate, and associate members of the Medical Reform Group. All members shall be notified in writing of such a meeting at least one month in advance. Such notice shall include a draft agenda.

22. Any Medical Reform Group member may attend any meeting of the organization.

23. There shall be a minimum of one General Membership meeting held each year.

24. The Steering Committee may call a General Membership meeting at any time by a majority vote at a meeting of the Steering Committee.

25. On the petition of a minimum of 20 per cent of the paid up full membership, the Steering Committee must call a meeting of the General Membership, with notice of the resolution to be debated given 45 days in advance so as to accommodate the notice provisions of Article 28.

26. In addition to powers enumerated elsewhere in this Constitution, a meeting of the General Membership may pass specific motions or instructions on any aspect of the

affairs of the Medical Reform Group of Ontario that are binding on the Steering Committee and Ad Hoc Working Groups in the exercise of their powers as stated elsewhere in this Constitution.

27. Any Medical Reform Group member who repeatedly acts in contravention of the principles of the Group, or in violation of this Constitution, may be subject to expulsion on the basis of a 2/3 vote of a General Membership meeting.

VOTING

28. Unless otherwise specified in this Constitution, any decision made by any body of the Medical Reform Group shall be by simple majority of voting members present at a duly constituted Membership meeting. Voting procedures in any body of the Medical Reform Group shall be as determined by the Chairperson of the meeting at which the vote is taken, and may include electronic polling according to procedures to be determined by the Steering Committee.

REVENUES

29. All monies and chattels accepted by the Medical Reform shall be the property of the Medical Reform Group of Ontario.

FILES AND RECORDS

30. All files and records of the Medical Reform Group of Ontario, except those relating to the ongoing work of a Working Committee, shall be maintained by the Regional Executive at the regional level and by the Secretary at the provincial level, and shall be accessible

only to members of the Medical Reform Group unless otherwise directed by the Regional Executive or the Steering Committee.

31. Use of the mailing list of the regional or provincial organizations for purposes other than those directly related to the ongoing activities of the Medical Reform Group shall only be as permitted by a majority vote of a Regional or General Membership meeting. Any member of the organization may request that his or her name be removed from the list when it is used for purposes other than those directly relating to the ongoing activities of the Medical Reform Group or its Working Committees.

AMENDMENT

32. For the purposes of amending this Constitution, a quorum of 30% of the full members of the organization must be constituted. In a meeting so constituted, this Constitution may be amended by a 2/3 majority of voting members present, so long as the provisions of Articles 28 to 33 inclusive have been met. If after presentation at a general membership meeting a quorum is not achieved, a mail-in vote may be taken. Ballots must be received from 30% of the total voting membership, and a two-thirds majority of the mailed-in vote is required to pass a constitutional amendment. The votes must be received within a time specified at the time of notification of motion.

33. This Constitution shall be subject to review at a General Membership meeting to be held one year after its adoption. ♦

ANOTHER CHARTER CHALLENGE?

with files from Colleen Fuller, Society for Diabetic Rights

Advertising of prescription medicines to the public is illegal in Canada as in all countries except the U.S. and New Zealand. This advertising is prohibited because of the inherent risks of prescription medicine use and the need for people with serious diseases to receive appropriate care.

By stimulating use of medicines beyond when they are needed, advertising can lead to otherwise avoidable harm. Medicines are also a leading cost driver, and we now pay more for medicines than for doctors each year in Canada. Health economist Steve Morgan has estimated that U.S. style advertising would add another \$10 billion per year to spending on drugs in Canada. Drug costs are already increasing at 13 per cent per year, a major contributor to rising insurance premiums and declining private health benefits among employees and retirees. Insurance premiums are expected to go up even more, along with individual out-of-pocket costs.

Poor enforcement of the current law

Despite our law banning direct-to-consumer advertising (DTCA), we see a lot of these ads in Canada. This is happening in two ways: cross-border U.S. ads on cable TV and in magazines, and 'made-in-Canada' advertising that stretches the limits of the law – and beyond. Cable TV providers already often substitute U.S. advertisements with local advertising for marketing reasons; they could also be required to replace advertising that is illegal in Canada. Similarly, magazine publishers could be asked to sell editions of their magazines without drug ads in

Canada. They already do this for UK editions of magazines.

Since 2000, Health Canada has also judged 'made-in-Canada' branded reminder ads to be legal. These ads mention the name of the drug but not what it is for. Reminder ads can be just as effective as full product ads in stimulating sales, and fail to warn consumers of drug risks.

In summary, there is a serious problem with lax enforcement of our current law.

Can West Charter Challenge

CanWest MediaWorks is currently suing the federal government in the Ontario Superior Court, claiming that the ban on direct-to-consumer advertising (DTCA) is an infringement of the Charter of Rights guarantee of freedom of expression. The company's main argument is that the ban on DTCA puts it at an unfair competitive disadvantage compared to US media.

Health Canada is defending the law against CanWest's Charter challenge. Additionally, an 'ad hoc coalition' including the Canadian Health Coalition, Canadian Federation of Nurses Unions, Canadian Union of Public Employees, Communications, Energy and Paperworkers Union of Canada, Medical Reform Group, Society for Diabetic Rights, Women and Health Protection and Terence Young have obtained standing in court.

A second court case on non-enforcement

Last summer, CanWest filed a second legal case in federal court, trying to compel the government to enforce the current law. This may seem inconsistent with CanWest's Charter Challenge, but is consistent with the

company's concerns about being at a competitive disadvantage for advertising revenues. The federal government was successful in having this application dismissed because the company had not established that it was harmed nor that it was representing public interests. However, the judge stated explicitly that had this case been brought forward by the ad hoc coalition, we likely would have been granted status because we do represent public interests.

An urgent need for action

If the widespread and adverse effects of drug advertising are to be avoided, the ban on DTCA must be properly enforced and sustained. The government's lax enforcement of the law seriously weakens its case in the Charter Challenge, a point that CanWest is vigorously making.

Further information is available by contacting medicalreform@sympatico.ca or Colleen Fuller at info@diabeticrights.ca ♦

NEWS ON EMERGENCY CONTRACEPTION

Here are the recommendations of the National Drug Scheduling Advisory Committee which provides for a period of comment up to May 14, 2008.

◆Levonorgestrel (when sold in concentrations of 1.5 mg per oral dosage unit, packaged and labelled for emergency contraception, in package sizes containing no more than 1.5 mg of levonorgestrel)”

Schedule III, pursuant to removal from federal Schedule F.

◆Levonorgestrel (when sold in concentrations of 0.75 mg per oral dosage unit to be taken as a single dose of 1.5 mg, packaged and labelled for emergency contraception, in package sizes containing no more than 1.5 mg of levonorgestrel)”

Schedule III (from Schedule II).

◆Levonorgestrel when sold in concentrations of 0.75 mg per oral dosage unit (except when labelled to be taken as a single dose of 1.5 mg and in package sizes containing no more than 1.5 mg levonorgestrel, packaged and labelled for emergency contraception)”

Retain in Schedule II. ◆

MRG MEMBERSHIP APPLICATION

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

Membership Fees

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

Please specify membership category:

Please specify areas of interest and expertise:

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

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

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

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

Account holder's name (print)

Account holder's signature

Date

SPRING MEMBERS MEETING

Thursday, May 29, 2008; 7 PM

featuring

Arlene Bierman, Geriatrician/Health Services Researcher

Gary Bloch, Family Physician

St. Michael's Hospital

- ◆ What are feasible and politically realistic actions that the Ontario government could take to reduce inequalities?
- ◆ What are feasible and politically realistic steps that a progressive Ontario government could take?
- ◆ What can the MRG do to further the cause?

Location to be announced

For more information contact medicalreform@sympatico.ca, check our website at [medicalreformgroup.ca](http://www.medicalreformgroup.ca) or call (416) 787-5246.

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