Medical Reform

Newsletter of the Medical Reform Group

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ACHIEVING EQUITY IN HEALTH

Ahmed Bayoumi

Who is in favour of inequality? It would likely be hard to find anyone who would volunteer themselves as being against "equality" – it's like saying you're against kindness or fairness or ice cream or other good things in life. But if we dig little deeper, things quickly become more confusing. We might all be cheerleaders for equality but it is not at all obvious that we are talking about the same thing. The salient question is not, therefore, whether we are in favour of equality but rather *what* thing we wish to be equal.

To illustrate, consider income. Would a just society be one in which income is distributed equally among all members? Or would we be willing to accept unequal distribution of income because some people might have greater need than others? Some might argue that justice has nothing to do with the distribution of income but is really about making sure that all people have the same opportunity to earn an income.

Or perhaps society should not be concerned about granting opportunities but only rights – that is, a just society would be one where all have the same right to access opportunities to earn income.

Similar arguments have been made about health. What constitutes a fair and just health policy? Should public policy be focused on ensuring that health outcomes are equal across groups? Alternatively, policy could be focused on ensuring that all groups have equal access to health care.

Or perhaps policy should only focus on the right to health care (and not at all concerned about who is actually getting care or their outcomes). The last position might seem somewhat extreme, perhaps overly libertarian, but it reflects the position of many right-wing governments who have expressed little interest in addressing inequities in health or other outcomes.

The current Ontario government has promised something different. One of their most exciting undertakings is a strategic research initiative in equity and health and human service. This is a cross-government initiative, which recognizes equity as a priority for the Ontario government and aims to establish an evidence base and build a toolkit for the horizontal coordination of health and human services across ministries.

The ultimate objective is increased equity and social well-being alongside more efficient allocation of resources. Steps in this strategy include reviewing service provision with regards to equity, reviewing policy levers and tools, establishing capacity to measure equity, and investigating the "public value" of equity.

These are fine sentiments, but translating them into policy decisions may be more difficult. The definition of equity is ultimately about values, so advocacy groups like the Medical Reform Group will have an important role to play in promoting their concepts of social justice. Alongside the government's poverty reduction

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MEDICAL REFORM GROUP FALL MEETING SEPTEMBER 17, 2008 TORONTO

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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

Two main issues are occupying the attention of members as we go to press this fall: addressing the health impacts of poverty on the health status of Ontarians, and maintaining and enhancing the integrity of publicly funded health care in our country.

While we were heartened by the election in Ontario last year of a party who had taken up our challenge to put poverty and its health effects on the public agenda, the process of ensuring forward movement on the agenda continues, as members can see from a review of our activity on this account. Especially gratifying was the collaboration of several of our Ontario members in the preparation of a series of 5 articles on poverty published in May and June in the Ontario Medical Review as a background for the Ontario Medical Association's policy development on the issue. While the Senate Committee on Health is preparing to conduct cross country hearings on poverty, there has been little direction or interest expressed by the Harper government.

The MRG fall meeting, with a presentation from the responsible senior bureaucrat in the Ontario Ministry of Health and Long Term Care promises to be an important educational component in building support in our sector for continuing this advocacy.

As I write, the new president of the Canadian Medical Association has made his inaugural address, urging more accommodation of for profit services in Canadian health care delivery. We continue to work with Canadian Doctors for Medicare in challenging such short-sightdeness.

Members continue to work on this and other issues with our allies in the Ontario Health Coalition --on enforcement at the provincial level of the Canada Health Act, and revitalizing the public debate on home care--and the Canadian Health Coalition, with continued monitoring of Bill C-51, on amendments to the federal Food and Drug Act, Direct to Consumer Advertising of Pharmaceuticals and advancing the campaign for national pharmacare.

Members are reminded to VOTE. You will find in this mailing a ballot seeking ratification by October 31, 2008 of a series of constitutional amendments proposed by the Steering Committee for more information on the work of the Steering Committee to modernize our by-laws, see issues 143 and 144.

Look forward in the next issue to an interview with long-time Steering Committee member Rosana Pellizzari who has recently been appointed Medical Officer of Health for Peterborough. ♦

ACHIEVING EQUITY IN HEALTH (continued)

strategy, these are times when we can make a difference in influencing policy to reflect progressive social values.

We are especially fortunate to have Dr. Adalsteinn Brown as a guest at our fall meeting. Dr. Brown is Assistant Deputy Minister in charge of the Ontario Ministry of Health and Long-Term Care's Health System Strategy Division. He also leads the Strategic Research Initiative in Equity and Health and Human Service as well as being an accomplished health services researcher before entering government. He has a strong commitment to promoting policies that are both equitable and evidence-based.

The fall meeting will be an invaluable time to hear about the equity strategy and to determine how the MRG can promote our vision and values. ♦

WORKING WITH ONTARIO'S CABINET COMMITTEE ON POVERTY REDUCTION

Janet Maher

Parallel to the Access and Eq uity Initiative of the Ministry of Health and Long Term Care, the Liberal Government in Ontario appointed the Hon. Deb Matthews, one of its most articulate anti-poverty advocates to head a Cabinet Committee on Poverty Reduction.

The Medical Reform Group joined many other community groups in the spring of 2008 to form a broadly based alliance—with the objective of holding the government accountable on its 2007 election commitment to poverty reduction. The alliance takes its name from one of the demands, to reduce poverty among Ontarians by 25 per cent by 2013 and by 50 per cent by 2018.

25 in 5 hosted a one-day conference April 14th, 2008 attracting some 400 community advocates who shared information and strategies.

Matthews spoke at the meeting, acknowledging how little had been done in recent years to address the growing gap between rich and poor in our province, and promised a wide-ranging consultation for solutions. Less than 3 weeks later, it transpired that the government had had a change of heart, and would undertake 13 regional consultations by invitation only.

The Medical Reform Group expressed its disappointment at this turn of events, but has continued to participate as appropriate in seeking government accountability. We continue to collaborate with other community groups to highlight the health impacts of inadequate income to meet basic human needs.

Several members came together with other progressive physicians to co-author a series of 5 articles published in the May and June issues of the Ontario Medical Review, as the Council of the Ontario Medical Association agreed to research and prepare a report on the health impacts of poverty for its members.

One of our members, Gary Bloch, participated in one of the Toronto Area Consultations on June 13th, 2008. Another, Catherine Oliver, assisted in the preparation of a brief to the Cabinet Committee on July 31st, 2008.

Yet others are consulting with a legal team who is preparing strategy for a challenge at the Ontario Human Rights Tribunal this fall of the 2006 changes in the Special Diet regulations section of provincial social assistance benefits.

Ontario members are continuing to work through the fall as the cabinet committee prepares its strategy and pverty reduction plan, to maintain pressure on the government to act on their acknowledgement that the most vulnerable Ontarians have fallen further behind than at any time in the past 20 years.

Copies of several of our interventions follos. For copies of the brief to the Ontario Government Finance Committee or the Ontario Medical Review articles, contact medicalreform@sympatico.ca. ♦

CONSULTING WITH ONTARIANS ON POVERTY REDUCTION

Gary Bloch wrote on behalf of the Medical Reform Group to call on Cabinet Committee Chair Deb Matthews to honour her April 14th commitment to consult broadly in the design of the government's strategy on poverty reduction with this letter of May 2nd, 2008.

We were very concerned to learn today that after your thoughtful presentation to the 25 in 5 Mobilization Day on April 14th, your government has opted for a consultation process around poverty reduction in Ontario which is limited to 13 communities with individuals selected by invitation only. We are particularly struck by the irony that low income Ontarians might have the wherewithal to make a comment via your website, given the resources to which most of them have access.

Twenty years ago, your Liberal predecessors saw the virtue in an inclusive consultation process headed by His Honour George Thomson. While some of that process was occasionally tense for the committee members and we all acknowledge that not all the recommendations he made were acted upon, there was both the appearance and reality of transparency to the process which facilitated the reforms which were acted upon.

We call on you to reconsider your decision immediately and ensure that all stakeholders are involved in a consultative process in the design of your poverty reduction strategy, and in particular that the vulnerable populations most at risk in this process have a place of honour at the table.♦

ONTARIO GOVERNMENT CONSULTATIONS ON A POVERTY REDUCTION STRATEGY

Gary Bloch attended one of 13 regional consultations held by Minister Matthews and filed the following report.

The Deb Matthews meeting was interesting, but not exactly revolutionary.

There were about 70 people at the session I attended, including some very good thinkers on poverty and health, for example, Toronto Medical Officer of Health, Dr. David McKeown, economist Armine Yalnizyan, heads of the shelter and housing divisions of the City, Jonah Schein, an advocate from the STOP, a west end food security organization, and representatives from many other community groups. Scattered through were a few people who actually experience poverty.

We were seated at tables of 7-10, and constrained by six questions, which included wording such as "what do you think can be done with existing resources". There was a big focus on child poverty, although every single table spoke out against this.

The most powerful moments by far came from the stories of people who live in poverty, making me question the value of bringing a whole bunch of smart but privileged people to spout out theories and ideas that have been spouted over and over again — the new approaches and ideas will come from hearing lived experience, I think.

Matthews is certainly an attentive listener, but I'm not in any way convinced this process will change where they are going. The closed-door nature of it is problematic, the lack of talking to significant numbers of people living in poverty is problematic, and the lack of a promise to publicly release the report from the consultations, or be held accountable to them is problematic.

But we shall see ... I still think better to be there than not, at least to see what's going into this process …♦

BUILDING ON ONTARIO'S STRENGTH: SUBMISSION TO THE CABINET COMMITTEE ON POVERTY REDUCTION

Presented July 31, 2008 to the Hon. Deb. Matthews, Chair of the Cabinet Committee on Poverty Reduction with the assistance of Catherine Oliver

The Medical Reform Group is a voluntary association of physicians and medical students which has advocated for nearly 30 years to improve the health of Ontarians and Canadians by monitoring the provision of public health care, and promoting equity and social justice. Like many social justice advocates across Ontario, they participate in the 25 in 5 Coalition which calls on the government of Ontario to act boldly to reduce poverty in our province by 25 per cent by 2013 and by 50 per cent by 2018.

We believe there is much we can do to improve the health status of all Ontarians and we welcome the opportunity to intervene on the issue of poverty reduction because of the well-established impacts of poverty on life-long health.

Why We Care

We live and work with low income patients who show the impacts of poverty:

- Population health: Low income Ontarians have
  - o 2 to 5 years shorter life expectancy,
  - o 60 per cent higher infant mortality,
  - o 43 per cent higher rates of low birth weight
  - o 24 per cent of person-years of life lost due to income-related causes

- Chronic disease: Low income Ontarians account for
  - o 25 to 30 per cent of cardiovascular disease mortality
  - o nearly 4 times higher incidence of diabetes in low income women

- Access to health services: Low income Ontarians have
  - o 23 per cent fewer angiograms,
  - o 40 per cent longer waits for diagnostic procedures

- Mental Health: Low income Ontarians experience
  - o a 60 per cent higher rate of depression

- Children: experience the effects of poverty throughout life

The Need for a Plan

We believe that poverty reduction starts with a plan – having a plan with a clear target for reducing poverty over a number of years is an innovative idea that has proven to work in other jurisdictions around the world. The United Kingdom reduced child poverty by nearly 25 per cent in the past 5 years. Quebec, as well as Newfoundland and Labrador have ambitious plans to tackle poverty. It's Ontario's turn.

We also believe Ontario will need a coordinated approach – that means that ministries must work together to break silos, engage in joint planning, and be accountable year after year for how we are progressing. All parts of government have a stake in the success of this plan.

What is Already Working

We have not been short in recent years on evidence on the impacts of poverty on health. The establishment of a research agenda by the Ontario Health Quality Council and its periodic reports on the links between income insecurity and chronic disease and disability are a testament to the costs of poverty and the need for early and aggressive strategy to address the allied issues of food and housing insecurity.

We believe the implementation of the Ontario Child Benefit and the commitment of the current government to expand its scope and value are an excellent first step in addressing the well-demonstrated disadvantage of childhood poverty as a determinant of adult health status. [According to University of Toronto economist Gordon Cleveland, and the Chief Public Health Officer of Canada, the government can achieve savings of $3-9 in future spending on health, criminal justice and social assistance for every $1 in early years investment.]

However, the Ontario Child Benefit is only an initial step, which has been compromised by the discontinuation of some discretionary benefits, such as the back to school allowance. It will be important in the transitional period of implementation to ensure bridging so that families who have relied on such allowances are not left in the lurch.

We have also observed some considerable debate on benchmark

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BUILDING ON ONTARIO'S STRENGTH: SUBMISSION TO THE CABINET COMMITTEE ON POVERTY REDUCTION (continued)

indicators and measures on the basis of which Ontarians might hold their government accountable for progress on the elimination of poverty in our province. While we look forward to a made-in-Ontario indicator[s], we do believe, with many others, that there is a basis for building and comparison which can be used on at least an interim basis.

We agree with the government that there must be recognized benchmark indicators for an Ontario poverty reduction strategy to ensure transparency and accountability. In fact Canada has two well-established and widely accepted indicators of poverty which we commend as the basis for building made-in-Ontario indicators as the strategy is implemented:

- The LICO (Low Income Cut-off) is an indicator of relative hardship which identifies households with insufficient income for necessities, contingencies and amenities based on average living conditions, and because it has a history of nearly 50 years in Canada, provides a comparability that will be difficult to replicate
- The LIM (Low Income Measure) is an indicator which identifies the proportion of adults and children living below 50 per cent of the median income for their group, and similar to several European and United Nations measures, allows for international comparisons.

An additional measure that would make sense is mandating the collection and tracking of disaggregated data across all Ministries, Departments and other relevant institutions in order to identify racialized and other structural and systemic disadvantage, develop clear definitions and indicators, in order to build a full and consistent picture as to who is poor in this province and why.

What We Ask

A commitment by the Ontario government to introduce a multi-year Poverty Reduction Plan in the 2009 provincial budget, outlining specific measures to lower poverty levels in Ontario by 25 per cent by 2013 and by 50 per cent by 2018.

We believe the core foundation of an Ontario Poverty Reduction Strategy should focus on creating conditions for all Ontarians to be healthy by coordinating cross-sectoral approaches with the objective of

- upgrading living conditions by assuring access to decent household incomes and basic life opportunities so that
  - o any parent or adult working full-time, full year in Ontario should have a standard of living above the poverty line
  - o supports are accessible for a life of dignity and adequacy for those in partial employment or unavailable for employment
  - o access is available to social resources such as affordable housing, transit mobility, child care, inclusive schools, continuing education and training supports, unemployment and health benefits; and

- strengthening local supports through building strong and stable community infrastructure that includes and engages vulnerable populations, with
  - o core funding for networks of neighbourhood voluntary agencies to develop and sustain community engagement and advocacy, and
  - o responsive public services in priority areas such as food security, recreation, settlement and crisis support

Recommendations

In collaboration with many community groups across the province, the Medical Reform Group supports the call of the 25 in 5 Coalition for a reduction of poverty by 25 per cent by 2012 and 50 per cent by 2017.

Some of the measures we think will be central to achieving that objective include:

1. Undertake a comprehensive review of social assistance rates and how they interact which other social programs to eliminate well-recognized perverse incentives. As Minister Matthews' 2004 report states, many of these rules are punitive –designed not to support people but rather to keep them out of the system.

2. Work together with other levels of government and government programs to coordinate universal and targeted programs to provide the most effective strategies for poverty reduction [for example, a universal national drug insurance program has the potential to address needs of a range of lower and moderate income Ontarians/Canadians

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BUILDING ON ONTARIO'S STRENGTH: SUBMISSION TO THE CABINET COMMITTEE ON POVERTY REDUCTION (continued)

while maintaining a stake in all residents in poverty-reduction measures; there is also considerable scope for more creative use of provincial public health protocols like the Nutritious Food Basket standard.]

3. Coordinate with and invest in housing and education programs to improve access for those at lower and moderate levels of income. This can include working with government and private sector partners to maintain access to recreational programs/facilities in schools and communities using existing infrastructure.

4. To ensure that full time work lifts families out of poverty the Ontario Government should increase the minimum wage to $10.25 per hour now, and index it to inflation. The government needs to update the Employment Standards Act to give contract, temporary, and self employed workers the same protections under our labour legislation as full time workers have.

5. The Ontario Government should press the federal government to play its role in an effective poverty reduction strategy:

- increase the Canada Child Tax Benefit to $5,200 per year for low income families;
- improve access to Employment Insurance; and
- provide funding for a national child care program and a national affordable housing strategy.♦

UNHEALTHY APPROACH TO HOSPITALS

In a follow-up to his article in the Spring issue of MEDICAL REFORM, Norman Kalant presented some recent evidence of the shortcomings of P3s in Ontario, in this letter to the editor of the Toronto Star, published May 13, 2008.

Tom Closson of the Ontario Hospital Association proposes that public-private partnerships (P3s) be used to finance the building of new hospitals (**Letter, P3s mean more hospitals, May 9)**.

Although the serious problems with this mode of financing have often been presented, Closson simply ignores them and fails to learn from the experience.

In Britain, many hospitals have been built using this model, and the cost was much higher than using the traditional approach – an average cost overrun of 72 per cent. A major factor in this was the high cost of financing – 22 per cent of construction costs. The cost of borrowing was 9.9 per cent, compared to the traditional cost of 3 to 3.5 per cent for government borrowing.

The number of beds in the finished project was an average of 27 per cent lower than the number originally considered necessary to meet the needs of the community.

The experience with the Brampton Civic Hospital has mirrored that in Britain. The original plan called for the construction of a new hospital and renovation of the existing Grace Hospital to provide 608 beds at a total cost of $350 million – the work to be completed in October 2005.

Despite repeated statements from government officials that building was on schedule and there would be no cost overruns, the new hospital was not opened until October 2007 and the Grace Hospital was scrapped.

This provided just 479 beds, and the final cost was $650 million, an 80 per cent overrun.

It is clear that in continuing to promote P3s, Closson has learned nothing from the experience of others or else is determined to destroy the public, not-for-profit system.♦

ONTARIO HEALTH COALITION COMMISSIONS A PANEL ON HOME CARE

In an attempt to mobilize opinion on home care in Ontario, the Ontario Health Coalition commisisoned a non-partisan panel consisting of Carol Kushner, Patricia Baranek and Marion Dewar, and sponsored a series of cross-province hearings in June, 20008 to gather submissions from patients, family members, providers, seniors, and other advocates. MRG member James Sugiyama offered his experience and observations for the submisison which is reproduced below.

The Medical Reform Group is pleased to contribute to this opportunity provided by the leadership of the Ontario Health Coalition to consider the current state of home care in Ontario today and what can be done to make it more responsive both to the Ontarians who can or do use it and to integrate it more coherently in health care service provision.

Although the brief makes recommendations touching on most of the points in the discussion paper, the presentation is focused, and relies primarily on the direct experience of one of our long-time members, Dr. James Sugiyama, who has included in his practice home care for predominantly frail elderly and marginalized rooming house residents in west central Toronto. Dr. Sugiyama, who previously worked at a west end community health centre, is a family physician, currently part of a family health network.

1. Principles and Goals

Home care should be seen as an integral part of our health care delivery system and governed by the same principles which govern the rest of public health care in our country, that is, universality, comprehensiveness, accessibility, portability and public administration. Those principles should apply to the full range of services currently provided as part of home care in Ontario—medical, nursing, social work and personal support services.

Home care needs to be seen primarily as a quality of life issue and not just a savings strategy for government. It must not continue to rely on the good will of family members where those exist or of the labour force of poorly paid personal support workers, who are predominantly immigrant women.

2. Access

We view the debates over the scope of services in the home care basket in isolation from health care more generally as missing the point, which is to maintain the quality of life of Ontarians who can benefit from supports. We do not support means testing of services, which tends to operate as a barrier to service often at the time it is most needed.

Further, we oppose caps or limits on services and think that the determination of services to be provided in a given situation can best be provided by those directly involved in the care of a patient, in the context of overall health care delivery.

We acknowledge there is a role for legislation and regulation of home care in legislation in providing a framework for accountability for community-sensitive agencies that can accommodate local needs and integrate with existing structures.

We think there is much to commend the hub-based approach typified in the community health centre model which assembles a multi-disciplinary team responsive to community needs and accountable to community governance to address the home care and health needs of communities.

The comprehensive approach fostered in these settings allows for a regular rather than crisis case conferencing which can both be more cost effective and provide more consistent and better quality care for vulnerable clients.

Options for integrating more comprehensive care options in primary care models like the family health networks and family health teams and should include consideration of funding and practice improvements.

Recommendation 1:

Consider facilitating a comprehensive case management approach in home care administration which can accommodate regular monitoring of client needs and services.

In our experience there is a major challenge in the current set-up which could be addressed more cost effectively by better coordination with the hospital sector. Sugiyama notes that although the system seems to exist to facilitate early discharge of clients, returning them to hospital easily for diagnostic procedures is difficult if not impossible, and

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ONTARIO HEALTH COALITION COMMISSIONS A PANEL ON HOME CARE (continued)

can require the family or front line providers considerable energy in arranging for tests on different days and at different locations—time which could be better spent on care.

Sugiyama notes the ironies of current requirements of mobility assessments which it appears can no longer be done in the home. He commends us to consider alternatives which might include elective hospital admissions for tests.

Recommendation 2:

Consider integrating diagnostic tests for home care clients in a central unit which would coordinate elective admissions for this purpose.

3. Funding and Providers

Even in the past 20 years, there has been considerable variability in the availability of home care services. Personal support services took a particular hit between after about 1995, without an appreciable change in cost to the system, but adding significantly to the burden on families. Language-specific services have never been well-supported in the sector and there is a need for more consistent provision of visiting nurse supports.

The therapeutic importance for many home care clients of seeing a physician should not be ignored. Moreover, a range of allied health services could add significantly to the quality of life available to home care clients and often more cost-effectively and humanely than in acute care settings. Included here would be chiropody, occupational therapy and physiotherapy.

Recommendation 3

Consider facilitating the provision of allied health services in a multi-disciplinary hub which would provide assessments and regular case management for the clients in a given catchment area.

Recommendation 4:

Address the inconsistency and lack of fairness in service provision by reviewing the pay and working conditions in particular for personal support workers who carry a significant workload but are currently at the mercy of the community care access centres.

4. Processes

As in other sectors, administrative processes often function more as barriers than facilitators of good service provision. To the extent that successes in assessment can determine client access to services, we acknowledge that those with experience in the sector can often navigate the processes more easily than those who have more limited contact.

We commend to the task force a review of the experience of Dr. Mark Novachinsky, whose collaboration with the National Film board resulted in the documentary HOUSE CALLS. Novachinsky has added profile to the issues faced by families and service providers in the sector, and makes a powerful argument for seeking funding solutions which make it possible for more family physicians to accommodate house calls and home care services more generally in their practices.

Recommendation 5:

Consider funding options which would remunerate providers, including physicians and nurse practitioners to ensure more consistency of service in the home care sector.

5. Human Resources

Where there is family, and this is not often the case with low income recipients of home care, the family already sacrifices significantly both financially as they reorganize work obligations to accommodate home care demands as well as physical and mental stress of care.

This often results in burnout among informal providers, and crises in care which have the potential to begin a vicious cycle of inconsistent care, with particularly serious impacts on older isolated clients. The current tendency of the Community Care Access Centres to seek the cheapest providers often aggravates and contributes to high turnover which Sugiyama acknowledges is likely the most pressing issue in home care.

Recommendation 6:

Adopt a cost-benefit analysis in the awarding of service contracts

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ONTARIO HEALTH COALITION COMMISSIONS A PANEL ON HOME CARE (continued)

which considers the health system-wide impacts of inadequate home care provision. We believe such an approach will see the virtue of not for profit provision which allows for directing all resources to service provision without consideration of profit.

6. Best practices

Sugiyama made several observations which might best be characterized as learning from experience or adopting best practices based on the lessons of the sector, including:

Recommendation 7:

Consider lessons of current palliative care groups which could be extended to home care as a whole.

Recommendation 8:

Consider payment mechanisms to support physicians who limit their practices to home care exclusively.

Recommendation 9:

Consider shared care models which would include more effective use of nurse practitioners and internationally-trained health care professionals in a shared care model that might be delivered in a multidisciplinary central agency that is more hub-like, for example on the model of community health centres.

Recommendation 10:

Consider more public information and/or more transparency on the existing complaints process to improve accountability.

Recommendation 11:

Consider practice guidelines which make regular, not crisis, case conferencing the norm.

Recommendation 12:

Consider expanded roles for allied health providers such as kinesiologists in prevention initiatives for the frail elderly.

In this context, Sugiyama referred to a demonstration project in west Metro that supported personal support workers teaching 10 exercises to frail elderly, with the observation that this approach might be appropriate for fall prevention.♦

CONSTITUTIONAL AMENDMENTS

In Issue 144 of MEDICAL REFORM, we gave notice for the May 29th, 2008 members' meeting, and presented the recommendations of the Medical Reform Group Steering Committee on a series of amendments intended to modernize the constitution.

Unfortunately, the hiqh quorum requirement for the members' meeting was not met, and so the 1980 constitution provides for a mail ballot of 30 per cent of paid up members to ratify the recommendations of the Steering Committee.

Ballots have been prepared with a summary of the issues and should be returned no later than Friday, October 31, 2008, by mail, fax or frowarded by email as a scanned image.

Enclosed with the hard copy of this newsletter for all members [not subscribers], is a mail ballot, which seeks approval of the amendments, which are summarized below:

a] Amendment of the Statement of Principles to reflect evidence of the role of social determinants and their effects on health;

b] Elimination of the requirement for 2 memebers' meetings annually in favour of an annual meeting in the fall and additional educational meetings at the discretion of the Steering Committee and/or the members;

c] Amendment of the composition of the Steering Committee, to a minimum of 7 persons with at least one student, and with a normal term of office of three years.

d] Design of a plan for electronic polling on issues of concern to members.

For more information, please see MEDICAL REFORM, issues 143 and 144, or contact administrator Janet Maher, at (416) 787-5246 or medicalreform@sympatico.ca.♦

MRG JOINS ADVOCACY ON BILL C-484, PRIVATE MEMBER'S BILL ON UNBORN VICTIMS OF CRIME

Almost under the radar, a private member's bill, c-484 passed second reading earlier this year, and could come to a vote at the next session of Parliament. On July 10, 2008, members of the MRG working group on reproductive health sent the following messages to all MPs.

The Medical Reform Group is a voluntary association of physicians and medical students who have campaigned for universally accessible high quality health care for all residents of Canada since 1979.

Along with many Canadians, we are repulsed by crimes of violence, especially those that injure not just a pregnant woman but also her unborn child and our hearts go out to the partners and families of these victims of crime. We believe that bill C-484 does a disservice to the women of Canada and jeopardizes their reproductive rights and freedom of choice regarding abortion.

Indeed we believe that that real issue that needs to be addressed by the Parliament is violence against women. Violence often increases during pregnancy and in the first few weeks after the birth of a child. If the Parliament wants to protect women and unborn children, it will invest in programs to end violence against women—affordable housing, regulated child care, improvements to maternity and parental leave.

Canadian law already permits a judge to increase the sentence for an offender who takes the life of pregnant women and their unborn child(ren). Since sentences are served concurrently, two counts of murder will make no difference to the outcome of a conviction. The only real effect of Bill C-484 is its threat to a woman's right to choose. In US states where similar legislation is in place, women have been arrested for endangering a fetus.

Therefore, we do not support legislation that would put the rights of the pregnant woman in conflict with her unborn child. Bill C-484, the *Unborn Victims of Crime Act*, has the very real potential to create just such a situation.

The legislation before the Justice Committee purports not to deal with the issue of abortion. The Bill states in s. 238.1(7) that it would not apply in respect of the lawful termination of a pregnancy, or to any act or omission by the mother. It reads:

For greater certainty, this section does not apply in respect of conduct relating to the lawful termination of the pregnancy of the mother of the child to which the mother has consented;

(a) an act or omission that the person in good faith considers necessary to preserve the life of the mother of the child or the life of the child, or

(b) any act or omission by the mother of the child.

We urge members of Parliament to go behind that exemption, and look rather at the promoters of the Bill, and at the legacy of similar legislation in the United States. Ken Epp. M.P. has the strong support of such radical single-issue anti-abortion groups as "Campaign Life Coalition". Press releases promoting the Bill have been made by a group with the misleading name of "Women for Women's Health", whose media contact was listed as one of the media spokespeople for "Campaign Life Coalition".

Fetal homicide laws have been passed in 37 states in the United States. As in Bill C-484, these laws purport not to affect abortion laws. In promoting the law, some legislators are very clear that the real intent is to try to overturn abortion law. The experience in the U.S. has been that it is women or young people who are charged under the law. A very thorough review of fetal homicide laws and "unborn victims of violence act" laws in the U.S. has been carried out by an organization called "National Advocates for Pregnant Women (NAPW).

This analysis reviewed the laws of many states, and concluded that such laws have become tools for policing and punishing pregnant women. The analysis also concluded that such laws have not led to a reduction in violence against pregnant women. In the cases reviewed, the charges against the women are laid even though the legislation exempts them, as does the Bill before this Committee.

Bill C-484 takes the focus away from the real issue, of domestic violence and violence against women. Homicide is the leading cause of death for pregnant women and new mothers, and domestic abuse increases during pregnancy. In almost every one of the most recent deaths of pregnant women in Canada, a male partner has been charged with the crime.

The strongest protection for an unborn child would be better measures to protect women in general, and pregnant women in particular, from

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MRG JOINS ADVOCACY ON BILL C-484, PRIVATE MEMBER'S BILL ON UNBORN VICTIMS OF CRIME (CONTINUED)

violence. We would support a law that calls for harsher penalties if the victim of violence was a pregnant woman. For example:

I. We would also endorse the laying of a more serious charge, such as aggravated assault, in the case of assault on a pregnant woman.

II. In the case of murder of a pregnant woman, the charge might be murder rather than manslaughter.

III. Parole provisions for such offences could be more onerous, when both a woman and an unborn child were victims of one offence.

All of these measures would show value for the unborn child while safeguarding the right to obtain a safe and legal abortion.

In conclusion, the Medical Reform Group, along with the majority of Canadians, values life. We do not think that the dialogue should be about competing rights but rather, about values. We should be striving for laws which honour and address our Canadian values, rather than laws which set up competing rights.

Clearly, Canadians value a society in which women are considered to be autonomous beings, capable of making legal and moral decisions. As a society we want women, pregnant and otherwise, to be free from violence. We believe that both values could be achieved by enhancing laws addressing violence against women, and that the current Bill C-484 would set up a rights competition which would not benefit either pregnant women, their unborn children, their families, or Canadian society as a whole. ♦

Debby Copes MD
Catherine Oliver MD
Rosana Pellizzari MD
Fran Scott MD

MORGENTALER APPOINTED TO ORDER OF CANADA

Members will have noted that long time abortion rights activist Dr. Henry Morgentaler was appointed to the Order of Canada on July 2nd this year, giving rise to some intemperate outbursts from anti-woman and anti-choice advocates.

In common with many reproductive rights advocates across the country, we were pleased at the announcement of the homour for Dr. Morgentaler, and given the media furore, sent a message supporting the appointment to the Governor General, who is responsible for the committee which reviews such honours. ♦

TOUGHER REGULATION NEEDED FOR DRUG INDUSTRY

The edition of JAMA, the larg est 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 April 16, 2008

BILL C-51 KEEPS CONSUMERS IN THE DARK

The federal government has introduced a new bill, C-51, that deals with regulatory framework for drugs and other therapeutic products. While there are a number of controversial aspects of the legislation, the Medical Reform Groups sees one area in which the new legislation unequivocally lets Canadians down.

The pharmaceutical industry has a long and shameful history of hiding from the public studies that suggest drugs are not beneficial, and studies showing they are dangerous.

"The fundamental weakness of C-51 is that the bill fails in requirements for transparency in pharmaceutical regulation," explained MRG spokesperson Ahmed Bayoumi.

"The legislation should require that all data from human studies be made available to the public. Instead, the legislation allows companies to keep information on benefits and risks secret."

Making all human trial data publicly available would allow researchers to independently analyze the data provided to Health Canada. If these analyses agreed with the results provided by pharmaceutical and device companies and Health Canada's own analyses, the Canadian public would be reassured. If independent analysts reached different conclusions, the disagreement would raise a red flag mandating further investigation.

The new legislation keeps Health Canada's reviews of both successful and unsuccessful applications unavailable. It permits, but does not – as it should – require the government to make public information related to important drug risks.

"Failing to demand that all clinical trial results be publicly available is putting the interests of the industry – which we know behaves badly to the detriment of Canadians' health - ahead of the interests of the Canadian public," Dr. Bayoumi concluded. "The MRG calls on the government to amend the legislation to address this major shortcoming."♦

Released May 26, 2008

MRG SUGGESTIONS FOR IMPROVING FEDERAL BILL C-51 AMENDMENTS TO THE FEDERAL FOOD AND DRUG ACT

Steering Committee member Irfan Dhalla sent the following letter May 26th, 2008 to Minister Clement and members of the Commons Standing Committee on Health as they reriewed amendments to the federal Food and Drug Act. For copies of Dhalla's paper, please contact the Medical Reform Group

The Honourable Tony Clement, P.C., M.P.
Health Canada
Brooke Claxton Building, Tunney's Pasture
Postal Locator: 0906C
Ottawa, Ontario K1A 0K9

Dear Minister Clement:

Re: Suggestions for improving Bill C-51

I am writing to you on behalf of the Medical Reform Group regarding Bill C-51, *An Act to amend the Food and Drug Act and to make consequential amendments to other Acts*.

The Medical Reform Group is a voluntary association of physicians and medical students who have advocated for over 25 years to maintain and enhance public health care in Canada.

We are pleased that the government has recognized that the current regulatory framework for drugs and other therapeutic products is in need of reform. The proposed bill has much strength, but we have also identified a significant weakness which we focus on in this letter.

The fundamental weakness we have identified is that the bill does not require as much transparency in pharmaceutical regulation as it should.

Although pharmaceutical companies, device manufacturers and other organizations involved in the manufacture and sale of therapeutic products have a *prima facie* right to keep certain data confidential in order to protect their commercial interests, we believe their claim is superseded by the right of Canadians to know all relevant information about drugs and devices that are being recommended to them.

I have attached a commentary that Dr. Andreas Laupacis and I published recently in the Canadian Medical Association Journal that discusses this issue in more detail. **The key point relevant to C-51 is that all data from human studies should be made available to the public**. Although the proposed Bill gives the Minster the power to compel pharmaceutical and device companies to perform clinical trials and report their results to the Minister, the Bill does not mandate these companies to disclose *all* human trial data, nor does it require these data to be made publicly available. With respect to the latter point, the Bill states only that the Minister "may disclose to the public information about the risks or benefits that are associated with a therapeutic product."

Making all human trial data publicly available would allow researchers to independently analyze the data provided to Health Canada. If these analyses corroborated the results provided by pharmaceutical and device companies and Health Canada's own analyses, Health Canada (and the Canadian public) would have increased confidence that the analyses on which it relied were fundamentally correct. If independent analysts reached different conclusions, Health Canada might choose to study the issue further or it might reach a different decision than it would have if it relied only on its own analyses. In either case, Canadians would have increased confidence in the decisions made by Health Canada and Health Canada would be more likely to make the right decision.

For the same reasons, Health Canada's reviews of both successful and unsuccessful applications should also be freely available on Health Canada's website. Canadians must be able to assess the quality of their regulator's review and understand its reasoning.

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MRG SUGGESTIONS FOR IMPROVING FEDERAL BILL C-51 AMENDMENTS TO THE FEDERAL FOOD AND DRUG ACT (continued)

Recent high-profile incidents concerning several drugs (e.g., Vioxx, Vytorin, Avandia, etc.) have clearly demonstrated the folly in keeping clinical trial data secret. In the Vioxx case alone, there have likely been tens of thousands of individuals in the United States and Canada who have had major, avoidable adverse events (e.g., heart attacks, stroke and death) as a result of a flawed regulatory system.

Bill C-51 provides the government with a chance to make changes to the regulatory system that will decrease the risk of Vioxx-like tragedies occurring in the future. We hope that the government seizes this opportunity and amends the bill so that all human clinical trial data and Health Canada's reviews are made publicly available. ♦

Sincerely yours,

Irfan Dhalla, MD, FRCPC
Att. *Dhalla CMAJ Moving from opacity to transparency in pharmaceutical policy Feb 12 2008.pdf*

cc. Members, Standing Committee on Health

Joy Smith, Chair	Christiane Gagnon, Vvice Chair
Lui Temelkovski, Vice Chair	Carolyn Bennett, member
Patrick Brown, Member	Patricia Davidson, Member
Steven Fletcher, Member	Susan Kadis, Member
Luc Malo, Member	Robert Thibault, Member
Judy Wasylycia-Leis, Member	

A HEALTH CARE LESSON FOR CANADA

Irfan Dhalla

Sixty years ago, British helath minister Aneurin Bevan officially inaugurated the National Health Service. Entirely free to patients and financed through taxes, the NHS was the first system of its kind – and its overnight success spurred similar reforms around the world. In Canada, these reforms started in the 1950s and culminated in the Canada Health Act, our own guarantee of health care based on need rather than ability to pay.

The British were ahead of us then and they are ahead of us now. In the past 10 years, the NHS has undergone a variety of reforms designed to improve the quality of health care and reduce waiting lists. Not all of these modifications have been successful, and some have been "rubbished" before the wrapping paper could be torn off. Yet, there is a growing sense that the British are doing many things right.

On the 60th anniversary of the NHS, there are a number of lessons Canada can learn from the British experience.

1. You get what you pay for.

Recognizing that the quality of primary care was variable, the British government launched the world's most ambitious "pay for performance" scheme to reward doctors for doing the right things, such as immunizing most children in their practices and achieving blood pressure targets. The bureaucrats expected doctors to meet 75 per cent of their targets; instead, they hit 97 per cent in the first year of the scheme. Similarly, the government reduced wait times dramatically by paying hospitals to meet benchmarks. The results are hard to argue with – 98 per cent of MRIs and 90 per cent of colonoscopies are now performed within six weeks.

2. If we're going to pay for doctors and hospitals, we should also pay for prescription drugs.

When the NHS and medicare were founded, the few life-saving medications available were almost always administered in hospital. Over the decades, however, scientists have developed dozens, if not hundreds, of medications that extend or improve life. The NHS

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covers these drugs, but medicare doesn't. Perhaps because drugs are provided by the NHS, the British government has been much more aggressive about keeping prescribing costs down. As a result, pharmaceutical spending in the NHS grew at 1.7 per cent last year, compared with 7.2 per cent in Canada.

3. Quality is a national objective, not just the goal of each individual health-care provider.

Ask a British doctor who sets standards for patient care and the answer will always be the same: the National Institute of Health and Clinical Excellence. Guidelines exist in Canada as to how patients with particular conditions should be treated, but they are produced by different specialty societies and are of variable quality. They can be hard to find, sometimes one guideline conflicts with another, and sometimes they are just plain unrealistic.

NICE's guidelines are practical and supported by tools to aid with implementation. Moreover, NICE makes its decisions in a transparent manner free from government interference. Claude Castonguay, the father of Quebec's health-care system, recently recommended a NICE-like body for the province – a good idea, but better would be a national body that would avoid the duplication and conflict that will occur when each province sets up its own standard-setting agency.

4. Pilot projects aren't good enough.

How often do we hear of one hospital or clinic doing something ingenious while other communities continue to do things the same old (less successful) way? Health care is bedevilled by the difficulty of spreading new knowledge from one place to another. The NHS hasn't solved this problem entirely, but Britain has established a well-funded institute whose sole purpose is to promote the rapid spread of practices and ideas that work.

5. Privatization is not a panacea.

The British have been experimenting with contracting out some NHS services to private, for-profit treatment centres. So far, there's no evidence that the private sector is cheaper or better. Although official figures have not been released, there are increasingly frequent news reports of private centres having higher complication rates. If it turns out that using private providers within the NHS improves outcomes, we should take a closer look. But, until then, the British experience suggests we should resist entreaties from those who wish to marry big business with health care.

6. Not every illness requires a doctor.

When I developed strep throat last year in London, I went to a walk-in clinic staffed entirely by nurses. I received textbook care for a common, minor illness that does not require a physician's expertise. If you have a baby in the U.K., most, if not all, of your routine postnatal visits will be with a nurse. Similarly, Pap smears and routine health checks are done mostly by nurses. Of course, doctors are readily available for people with special needs or when an abnormality is found. But do we really need someone with 10 or more years of postsecondary education to see every patient at every visit? There are smarter and more cost-effective ways to use other health-care workers to improve quality and reduce wait times.

Perhaps the most important lesson we should learn from the NHS is that we cannot afford to rest on our laurels. Yes, we have an excellent health-care system, but anyone who works in it knows it could be better.

This is neither the fault of medicare's architects nor of individual health professionals. Disease patterns and available treatments have changed over the past 60 years, as have our expectations. Some of the institutions required to consistently deliver high-quality care in the 21st century do not yet exist. But looking at the NHS on its 60th birthday is a good way to start thinking about how we can build them.

Irfan Dhalla, a physician at St. Michael's Hospital in Toronto, is studying health policy as a Commonwealth Scholar at the London School of Economics. First published in the Globe and Mail July 3rd, 2008

MRG RESPONDS TO BC GOVERNMENT THREAT TO ABOLISH THERAPEUTICS INITIATIVE

Steering Committee member Gordon Guyatt wrote the BC Minister of Health on May 29th, 2008 to express concern at the proposal of a government task force to abolish the Therapeutics Initiative. Follloiwng many such expressions of concern, the BC government has relented, seeking a second opinion on their proposal

The Honourable George Abbott MLA
Minister of Health
Room 337
Parliament Buildings
Victoria BC
V8V 1X4

Re: the Pharmaceutical Task Force's assessment of the Therapeutics Initiative

Dear Minister:

As a voluntary association of physicians and medical students of over 25 years standing in public policy debates in this country, the Medical Reform Group is very disconcerted to read that your Pharmaceutical Task Force recommends abolishing the Therapeutics Initiative (TI).

Academic physicians and clinical practitioners, to say nothing of several generations of students and residents are consistently counseled to find the best possible sources when it comes to the assessment of medical products and services. When it comes to reviewing the evidence on pharmaceuticals, we believe there is no better resource in Canada than the TI. We know we are not alone in this view. Rarely has so much good work been produced with so little investment.

It was at first, therefore, astonishing to read that the review could possibly conclude with a recommendation to do away with it. Only when we learned more about the composition of the Task Force, and the fact that five of its nine members have ties with the pharmaceutical industry did their conclusions begin to make sense. It now makes perfect sense that such a group would recommend loosening the conflict of interest rules, ignoring the fact that all over the world there are increasing calls for tightening such rules.

Apart from the obvious skill and experience of those who work for the TI, what is most treasured by the broader community interested in medication issues is its independence. Access to accurate clinical trial information and systematic drug reviews is vital and the TI regularly provides this whereas manufacturers too often withhold critical data from the public resulting in misleading overestimations of drug efficacy and underestimations of potential harm. That independence has permitted it to serve the public interest in very concrete, measurable ways—saving dollars and lives in British Columbia.

The Therapeutics Initiative helps save lives in BC and saves BC taxpayers money. We urge you to listen to the many, including the CWHN, who strongly support the TI by continuing to give it your full support. We urge you to reject the idea of abolishing the TI and choose instead to retain and even strengthen its ability to apply good science to protect our health and our pocket-books.♦

WHERE IS THE INTERNATIONAL RESPONSE TO DEPRAVITY AND SEXUAL VIOLENCE IN DR CONGO?

: Brad MacIntosh

The Democratic Republic of the Congo (DRC) has been witness to an unprecedented level of violence and calamity, including countless instances of mass rapes and brutality directed at women.

A survey of sexual violence was conducted in an attempt to characterise the extent of sexual violence directed at women[1]. What is now clear is that instances where MONUC peace-keeping soldiers are perpetrators of sexual violence cannot be seen as isolated events.

A recent letter to the editor of JAMA by Taback and colleagues[2] highlights this disturbing phenomenon and the need to address the root causes. When people in positions of authority, such as MONUC soldiers and prison guards, are perpetrators it suggests that there is a systematic pattern of abuse of women. Impunity has created a belief that sexual violence is acceptable at all levels of the society in DRC.

The current climate begs the question whether the women of DRC will ever have the means to right the wrongs from the past decade of systematic abuses.

So it by no means an understatement to say that it was an historic occasion on June 18, 2008 when the UN Security Council's put forth a resolution denouncing sexual violence. The head needs to send a message to its hands – so to speak – a mechanism needs to be put in place when appendages of the UN act egregiously.

There are many questions that remain unanswered. For instance, what will come of the DRC, a country that has been witness to the worst humanitarian crises of the past decade? What role should the west play in facilitating the huge effort rehabilitating survivors of sexual violence and improving the status of women?

The organization SAFER (www.saferworld.ca) that was started in 2004 and has been partnering with the Panzi Hospital in Bukavu, South Kivu, DRC, is facilitating discussion in Canada. On November 28th 2008, SAFER is co-hosting an evening event with the Stephen Lewis Foundation. "Making the world SAFER: An evening to end sexual violence in the DRC" will take place at Convocation Hall, University of Toronto, featuring the director of the Pan Hospital, Dr. Denis Mukwege, as guest speaker..

Notes:

[1]Democratic Republic of Congo: rape as a weapon in North Kivu. Doctors Without Borders. MSF-USA: Field News. July 19, 2006.

[2]Taback N, Painter R, King B. Sexual violence in the Democratic Republic of the Congo. JAMA. 2008 Aug 13;300(6):653-4.

ADD THESE BLOGS TO YOUR BOOKMARKS

There is life after medicine for retired member Richard Pickering who has worked indefatigably to maintain the websites of the Medical Reform Group and Canadian Doctors for Meditcare.

In the past year Richard has designed and facilitated blogs for CDM and for long-time MRG member Gordon Guyatt.

Visit and contribute to these blogs for CDM at:

http://cdm-mcrp.blogspot.com/

and for Gord Guyatt:
http://guyattsblog.blogspot.com/

MRG MEMBERSHIP APPLICATION

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

Membership Fees

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	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:

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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.
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Account holder's name (print) | Account holder's signature | Date

FALL MEMBERS MEETING

Wednesday, September 17, 2008, 7 to 9 pm

ACHIEVING EQUITY IN HEALTH

with

DR. ADELSTEINN BROWN

Assistant Deputy Minister, Health Systems Strategy
Ontario Ministry of Health and Long Term Care

How can health providers address inequities in health and what can Medical Reform Group members and other activists do to advance the anti-poverty agenda through health?

University of Toronto location to be announced
For more information contact medicalreform@sympatico.ca,
check our website at medicalreformgroup.ca or call (416) 787-5246.

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]