

# Medical Reform

## Newsletter of the Medical Reform Group

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### ORGANIZING FOR MEDICARE

*Janet Maher and Ritika Goel*

On November 6th-8th, 2010, the Ontario Health Coalition organized a high-level briefing for members, to provide the basis for more strategic organizing in the next year. The briefing covered a range of issues, including the sustainability of publicly funded health care as defined in the Canada Health Act, as well as proposals to address long-acknowledged gaps such as comprehensive coverage for drugs and home care as well as more adequate supports for long-term care. There was also a focus on the rise of private clinics across Canada and legal challenges being undertaken regarding such breaches of the Canada Health Act.

The three days were full of knowledgeable speakers and panels including the following among many other talks:

1. Using the courts to dismantle public health care
2. Private clinics try to take down Medicare in BC
3. What does two-tier health care mean for Canadians
4. Cross-Canada Round-up
5. Legal issues and opportunities for intervention

Economist Robert Evans took on the issue of the unsustainability of Medicare in his keynote address by comparing a number of myths com-

mon in the media with the factual situation. A few examples showed what can happen in an apparently inflexible system with a little political will.

#### 1. Drug Prices

In response to a report of the federal competition bureau which noted the high prices of generic drugs, the Ontario government decided in the summer of 2010 to reduce the rate at which pharmacies are reimbursed for dispensing medications from 50 to 25% for the previously patented drug price. This applied to medications under the Ontario Drug Benefit and Trillium Drug Programs by enforcing a ban on the professional allowances paid by generic companies to pharmacies to stock their products. A few months later, the BC government made a similar announcement, reducing its reimbursement to the generic companies from 65 to 35%. As a matter of policy, Quebec has made a point of fixing its rate of reimbursement at the lowest rate of all the other provinces, and is in discussions at year end with the manufacturers to achieve this. Since these three provinces account for approximately 75% of the Canadian population, it is likely that the other provinces will shortly follow suit. At minimum, the experience has given rise to a new level of discussion among provincial ministers

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Editorial committee this issue: Janet Maher and Ritika Goel

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*

**M**RG responded to the challenge of President-elect, now President of the CMA to join the debate on health care transformation by preparing two briefing notes (see issues 149 and 150). At the end of November, 2010, three of the Steering Committee members published an analysis of options to be considered in the ongoing sustainability debate, and highlights appear in the news release reproduced in this issue.

They will continue to work in the new year to add their voice of reason to the CMA consultation process early in the new year and to counteract facile media parroting of persistent myths around health care funding and access, like the canard about population ageing threatening to bring health care to 80 per cent of the Ontario provincial budget by 2030.

As can be surmised from our lead article this issue, MRG is not the only group organizing to dispel myths and organize an alternate media presence around real options for high quality health care across the country.

As the year drew to a close, the Canadian Medical Association announced the details of the public part of their consultation. They will be organizing a series of public meetings in the new year, but meanwhile, they do have a website at <http://healthcare-transformation.ca> which seeks answers from the public to 3 questions:

1. The law underpinning our system – the Canada Health Act – dates back to the 1980s. It covers only doctor and hospital care. Do you think it should be broadened to include things like pharmacare and long-term care?

2. It is important for citizens to feel they are receiving good value for their health care. What would you consider good value?

3. Patients and their families play an important part in their health care. What do you think Canadians' responsibilities are, now and in the future, in regards to their health?

As information on the public consultations becomes available, we will disseminate that information and plans for intervention through our electronic lists.

In preparing for this debate, if you are not connected with Canadian Doctors for Medicare, you may still want to check their recent paper on Activity Based Funding. Available on their website at [www.canadiandoc-torsformedicare.ca](http://www.canadiandoc-torsformedicare.ca), the paper clarifies the role of activity-based funding as a analytic tool for understanding health care costs in some very specific situations. The paper demonstrates that there is NO evidence that versions of activity based funding which have been tried in jurisdictions have done much of anything to reduce wait times or costs, and that there are some very large risks to moving in a direction that is likely to benefit few dependent on public health care. They conclude, as we anticipate the Ontario Auditor General might if he were to undertake a value for money audit, that activity based funding only makes sense as a limited experiment until and unless some of the most potentially costly risks can be controlled for.

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## ORGANIZING FOR MEDICARE (continued)

of health to address pharmaceutical costs which are the fastest growing costs in current health care budgets, as Ontario health minister Deb Matthews assured correspondents from the MRG.

### 2. Spending on physicians

All acknowledge an increase in expenditures on physicians, although the doctor-to-population ratio has remained the same since 1990 and hours of work are down on average. Evans counseled a look at specific categories: dramatic increases in lab tests, imaging and other diagnostic procedures, particularly in his home province of BC. In addition, he noted that alternative payment models (i.e., non fee-for-service) now account for a larger proportion of expenditures. While the latter may be a function of a more fulsome attempt to implement primary care reform, the increases in diagnostic procedures has also been noted in other recent commentaries, notably the Organization for Economic Cooperation and Development.

### 3. Grey Tsunami or Grey Glacier

Evans warned against attributing increased costs to the ageing of the population, characterizing that as simply scapegoating. While ageing is occurring and will cost more, the increase is of the order of less than one percent annually, as has been happening for most of the post-war period, and hardly accounts for the current rate of increases in cost. Even a cursory analysis reveals the actual health care spending has remained remarkably stable, but appears out of control because of government decisions to cut substantially the non-health care items in provincial and other budgets since 1980.

### Mythbusting

Evans suggested that a major area for focus and action is the regional variation in health care practice which can be particularly instructive. He cited Alter et al., who document the inverse relationship between the prevalence of heart disease and the number of cardiologists. This 2008 study attributes the level of treatments or interventions to the prevalence of cardiologists, not to the prevalence of disease. Evans also drew attention to the unnecessary overuse of ultrasound for normal, uncomplicated pregnancies where Ontario leads all Canadian provinces and many US states. The study of regional spending variations in the US has also led to conclusions that the greatest growth in costs occurs in areas which are the most supply-sensitive, that is in in-patient days in general, ICU/CCU days, evaluation and management and diagnostic testing as opposed to required screening or procedures which have varied little for a generation.

Additional perspectives and evidence for myth-busting were offered by Hugh Mackenzie and Pat Armstrong. Mackenzie, co-author with Michael Rachlis of the Sustainability of Medicare report noted that a recent TD Economics report predicting catastrophic results for health care assumes revenue would increase at 2% a year while expenditures would increase at 3% annually. Small wonder that the report anticipates health care accounting for 80% of the provincial budget by 2030, 'if nothing is done.' Mackenzie's other pet peeve focused on the revenue side, and the failure of governments in Ontario to acknowledge the impact of personal and corporate income tax cuts from 1996 to 2005 of the order of \$14 billion or the entire cost of elementary and

secondary education in the province in 2004-05.

Pat Armstrong focused her attention on the character of the so-called 'grey tsunami.' Her recent work revealed a considerable change in senior demographics, including that only 7% of those over 65 live in institutions, only 7% of those over 65 living in private homes need assistance and nearly 20% live with either children or grandchildren. Contrary to the received wisdom that older people do not contribute are data which reveal that up to 35% of grandparents who share their homes are financial providers for family members. One in 10 live in homes in which they are the primary care provider, predominantly unpaid, either for another senior or another family member—this is an increase of 20% in the past decade. In 2006, 15% of men and 6% of women over 65 were in the labour force. Her final point addressed the myth about handling the cost of the older demographic. While she noted that seniors do use the system more and their care is more costly, according to the Canadian Institute for Health Information, the cost of care for them has not risen relative to younger cohorts, and per capita costs for older Canadians actually decreased between 2001 and 2009.

### Private Care and Clinics

Natalie Mehra, Ontario Health Coalition director, reviewed some of the examples of private care in cataract surgery and physiotherapy. Cataract surgery is covered by OHIP at the rate of \$474 per eye and the current average wait is around 8 weeks (better than all other Canadian jurisdictions except New Brunswick). For those who want faster service, a private clinic in Mississauga charges

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## ORGANIZING FOR MEDICARE (continued)

\$1,200 to \$2,000 for a “special lens” which facilitates jumping the queue. It is not believed that this special lens offers any benefit over the traditional procedure. Physiotherapy was delisted from the OHIP scheduled services in 1998, and in order to balance budgets, most of the remaining physiotherapy services have since disappeared from the mix of hospital service offerings covered by operating grants to hospitals. This means that those requiring physiotherapy now pay unregulated fees of \$70 to \$100 for an initial assessment, then \$50 to \$70 for each additional service. To minimize their exposure, many private insurers are now limiting the volume of services per patient per year. Her advice for members was simple: design a clear program of reform for public health care which eliminates multiple levels of administration, build consensus and mobilize for that vision.

Ross Sutherland focused his attention on the diagnostic sector—labs and imaging companies which have long been largely private and continue to lobby against controls which might assist in reining in costs in that sector. Although data are still relatively disparate, his work has shown that this sector has lobbied against hospital-based testing facilities and against integration in the LHIN system.

In the western provinces, in contrast, private clinics have focused more directly on relatively high-volume day surgeries such as orthopaedic and ophthalmologic procedures. In a few cases, for example in Alberta, the loss of an exclusive government service contract also resulted in the bankruptcy of a private clinic. In an afternoon plenary, Natalie Mehra and Canadian Health Coalition director Mike McBane focused members’ attention on two main issues which are preoccupying the coalitions: re-

negotiation of the system of federal transfers slated to take effect in 2014, and a strategy for national pharmacare which begins to address one of the most relentless drivers of health care costs for most of the past generation.

### Federal Liberal Platform Plans

Federal Liberal health critic Ujjal Dosanjh referred to a 2006 Liberal commitment to come back to the table in 2007 with a plan for the expansion of home care which was abandoned when Harper formed his first minority government. If elected, the Liberals have plans to advance a \$1 billion Family Care package. He states their second priority is pharmacare with seems most likely to begin as a program for catastrophic drug coverage with co-payments and/or specified treatments. On the issue of renegotiating transfers, Dosanjh was less sanguine.

### Legal Options

Another series of panels brought together some of the legal experts who have been defenders of Medicare as counsel for provincial or federal health coalitions: Steven Shrybman, Martha Jackman, and Stephanie Drake.

Shrybman offered a context for many of the current legal cases by explaining the role of the Canadian Charter of Rights and Freedoms to ensure individual rights, frequently at odds with collective rights such as those asserted in the Canada Health Act, for example. Under the Charter, corporations have the status of individuals, so that they can argue, as CanWestGlobal was attempting in its challenge on the ban of Direct-to-Consumer Advertising, an infringement on their individual rights. Should this action succeed, it would increase the pressure and eventually the cost

of patent medicines. In Shrybman’s estimation, the infamous Chaoulli case has so far had a relatively limited impact since it was judged to offend the Quebec but not the Canadian charter. More problematic is the fact that it has since given rise to a number of similar cases or attempts at cases in other parts of the country in which the Canadian Charter would be directly tested.

Martha Jackman, spoke of her experience with the Charter Committee on Poverty Issues, and Stephanie Drake, acting for the BC Nurses Union, spoke of the strategic value of coalition organizing on the legal front. They both gave examples of matching the ‘opposition’ with pleadings on damage to the collective of asserting individual rights. Jackman had characterized the absence of access to a publicly funded health care system as a violation of life, liberty and security. Drake reported on some strategic freedom of information requests and organizing for intervenor status in the BC private clinics case, using similar tactics, and focusing on patient stories with dire consequences as a result of longer waitlists in the public system because of lack of capacity. Both spoke at length to the need for a tightly managed media and coalition campaign to complement the legal challenges.

Marie Claude Prémont spoke of some of the lessons from the Chaoulli decision, which she noted had a very limited impact there. While it ruled as the complainant sought on the Quebec Charter, it did not do the same on the core reason for the Quebec appeal which was to provide an entry for private health care insurance. On this issue, the judge did not deem the prohibition of private insurance that important since only

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## ORGANIZING FOR MEDICARE (continued)

6 provinces have the prohibition and private insurance is not that rampant. Her advice to the assembly, however, was to monitor provincial legislation to minimize the potential for incursions of the private sector. In particular, she saw the following core rules as necessary in each province: a prohibition of private health insurance, a prohibition on 'double-dipping' for physicians (billing private and public insurance at the same time or co-locating private and public billers under the same roof), regulation of fees for opted-out physicians to limit incentives to go private.

### Some Lessons of the Day

While most speakers had grave concerns about the difficulties foreseen with a federal government which appears to have little interest in the health of Canadians, nearly all had examples of small and medium-sized wins that would not have been achieved without consistent coalition-building, organizing and clear information dissemination both to members and the broader public.

Mike McBane recounted the experience of the New Brunswick

Coalition which had taken the privatization challenge on as a sustained public education campaign for the hearts and minds of citizens in the recent provincial Liberal government. In addition to information dissemination to its members, the coalition worked with the regions to have a presence in media and local lobby efforts. Within weeks, the minister who had suggested privatization and contracting out of clinics has resigned and the new minister began his tenure by announcing that privatization was off the table. In a debrief, it turned out some of the most critical coalition work included working with the bureaucrats who prepared briefings for the new minister.

McBane also spoke briefly to the Quebec fightback against aggressive privatization in diagnostic imaging and the 2009 provincial proposal for a \$25 user fee. He noted that the resistance is most noticeable among young physicians, residents and students, pushing for universal pharmacare and a government-run drug manufacturer to eliminate or avoid drug companies changing their business plans when the product

mix is no longer profitable. He also noted the short-lived health insurance proposal of the BC Automobile Association when the BC Health Coalition launched a media campaign. Another novel tactic employed by the Alberta Friends of Medicare involved collecting bills including charges for medically necessary services by private MRI providers. The government responded by immediately moving all MRI services to the public sector.

Shrybman emphasized that the courts are generally not the friends of Medicare. He has concerns that many of the cases in which we have had limited wins over the past decade, would not likely have the same result if the same or similar cases were now to emerge. However, he thinks the good news is that when defenders of Medicare organize and fight, they do win. To the extent the battle is political rather than primarily legal, he counsels a coherent and consistent media campaign to maintain the information flow to constituencies which support publicly funded health care. ♦

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## NATIONAL PHARMACARE STRATEGY

*Janet Maher*

**M**arc André Gagnon, a researcher at the School of Public Policy and Administration at Carleton and Guillaume Hébert recently released a detailed study, *The Economic Case for Universal Pharmacare*. They show that increasing the revenues of pharmaceutical companies does little to achieve any benefit for Canadians, beyond requiring Canadians to spend more than \$1.5 billion than average drug prices in other OECD countries. They argue not only that

public spending on pharmaceutical research and development would be more effectively focused on innovation rather than artificial support for drug prices. Moreover, they show that the piecemeal insurance system which currently constitutes drug coverage in Canada leaves us paying more per capita on drugs, exacerbate unequal access, and exclude large population groups. Although they admit establishing a national universal first dollar coverage plan will be a challenge, they conclude that the

only hindrance to beginning down that path is political apathy, not economic cost restraints.

For the full study go to the Canadian Centre for Policy Alternatives website at [www.policyalternatives.ca](http://www.policyalternatives.ca). ♦

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# PSYCHIATRY AND ANTI-POVERTY WORK

*Interviewer Janet Maher recently had a chance to discuss with University of Toronto psychiatry resident Michaela Beder about her experience and analysis of working with people living in poverty.*

*JM: I wonder if you can begin by talking about why you decided to specialize in psychiatry and what skills you bring to your current work?*

MB: There are a few factors. Psychiatry sometimes raises more questions than it answers, but it does give me a way to engage with both people and communities, and I enjoy working in a field that has controversy, that is evolving. I think one of the things that's really important is to make the link between these different areas; so when you're thinking for example about poverty and mental health, to go beyond the obvious, to think about the root causes of illness, and of suffering, and not to be seduced by an increasingly biological approach. This means that as practitioner I need to be equally skilled in looking at the social and human side of things and also the biological side. I have a background in philosophy, and psychiatry offers a space to really bring some of that critical analysis to healthcare. We obviously have to understand our patients and where they're coming from, but we also have to understand the power dynamics that happen between physicians and patients, the often dark history that our field has grown out of, and the current political implications of the work we do.

*JM: I know you have been active as a resident on the anti-poverty file. What brought you to that? What skills do you think you bring to this work specifically as a psychiatrist?*

MB: Well, I think that most of my skills come from outside of psychiatry, although that is changing as I advance in my training. There are certain skills in terms of group and interpersonal dynamics that you really learn in psychiatry. But a lot of my skill set actually comes from the community organizing that I've been part of. Over the past few years I have worked with various community organizations, including Health Providers Against Poverty, Health for All (a migrant justice organization fighting to improve access to health care for people without OHIP, and to ensure full immigration status for all), Students for Medicare, and the Medical Reform Group. Through working with these organizations I've certainly learned to see things on a more systemic level, and to locate myself within a system that is often constructed to benefit those who already hold power and privilege. I think, as a physician, one of the central challenges is the need to constantly question the power we hold and to use that questioning to continue to work towards social justice, to learn to speak in solidarity with people. I often think about the quote by the public health academic Navarro, "It's not inequality that kills people ... it is those who are responsible for these inequalities that kill people," which I take as a challenge to hold ourselves, our government, and our profession accountable.

In my work with Health for All I have learned so much, from how to put together conference presentations and panel discussions, to direct action and community mobilization, to working with media. Along with poverty, immigration status has a tremendous impact on people's health, and it is heartbreaking to know that there are over 200,000 people in Canada who do not have healthcare coverage. And to hear about people with severe mental illness, such as schizophrenia or bipolar disorder, who are deported to countries that cannot provide the care they need, due to their contact with the criminal justice system while they were sick.

One experience that has had tremendous influence on me is belonging to RACI, the Residents and Consumer-Survivor Initiative. The group, which meets once a month for informal discussion over food, was started by a couple of psychiatry residents and some amazing people from Voices from the Street, an advocacy organization of people who have direct experience living in poverty and oftentimes with mental health challenges as well. It's been very, very educational for me to hear from people directly, not when I'm their physician and they're my patient, but really breaking out of that and having people tell their stories.

That's where I met Linda Chamberlain. You may know the recent report by John Stapleton called "Zero Dol-

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## PSYCHIATRY AND ANTI-POVERTY WORK (continued)

lar Linda,” which tells her story; she’s had a very varied life, including a range of experiences within the mental health system. More recently, she worked at one of the psychiatric hospitals as a peer support worker. She lives in assisted housing and is supported by the Ontario Disability Support Program (ODSP), and has defied all the odds to go back to work. But when she went back to work and started actually earning some income, her housing costs shot up so much that she had to quit her job or risk losing her housing. And she’s not the only one who has suffered due to unfair ODSP rules.

The whole social welfare system consists of this level of bureaucratic, nonsensical rules. It is not created to facilitate people recovering or people getting better, and in fact often holds people back. Aside from the fact that people don’t have enough money to live on in the first place, getting outside of dependence is really difficult. I’ve heard Linda and others tell their stories, and one of the things the RACI members emphasize is the importance of having enough money to buy food, and clothing, and pay for housing, and of the ability to do meaningful and fairly compensated work. As psychiatrists, we need to learn to listen to people such as Linda, and to switch from an illness model and to consider what it means to recover, to live a good life.

JM: *So given that, tell me what you see as the link between poverty and mental illness, in your clinical practice?*

MB: Well, we know that people who have mental illness are more likely to live in poverty, and poverty is also a risk factor for mental illness. According to the Ontario Ministry of Community and Social Services in 2006, 35 per cent of ODSP clients had a mental illness, which may even be an underestimate. And once you are living it poverty, it is incredibly difficult to get out of poverty, since the social welfare system is not set up to help people get back on their feet. How can we expect people to go out and get work when they are living in unsafe housing, in rooming houses with insufficient heating, and with bedbugs. We often see people coming to the emergency departments, sometimes just to access a warm bed or somewhere safe, and I so often feel powerless to address the essentials of life: do people have enough money to get food, do people have a clean place to live? And so much of the poverty in our communities is actually hidden – if we don’t make a point of asking about peoples’ living conditions, we often don’t find out the dire nature of their circumstances.

I recently had an experience that illustrated this relationship between poverty and mental health. In September, there was a six-alarm fire on Wellesley Street, in a huge apartment block that is part of St. Jamestown, one of Toronto’s poorest neighbourhoods. Over 1,200 people were displaced. I went down as a volunteer and ended up helping to set up some of the medical services, since there is a big gap in the city’s current emergency preparedness plan in terms of primary care delivery. What was really noticeable was that there were not that many acute injuries, but there were many people with high levels of primary care needs and chronic illnesses, including a lot of psychiatric illnesses.

Had the fire happened in a different community, people may have better able to get to their family doctor or a pharmacy. But we saw people who couldn’t afford the \$6 fee to get their medications, who live with addictions, who struggled to understand what had happened. When an emergency hits, those living with very difficult mental health problems are disproportionately affected, as are those living in poverty. We need to start ensuring that communities are healthy before a disaster hits, rather than scrambling reactively to deal with the aftermath.

JM: *Do you think ‘treating’ mental illness is/ can be different than other ailments?*

MB: In some ways they’re very similar. In both cases, whether you’re physically ill or mentally ill, you need to be treated with respect. And in both cases your wellbeing will be affected by your level of income. Poverty is a well documented determinant of health; living in poverty puts you at risk for developing diabetes, cardiovascular disease, COPD, and many other severe illnesses. As well, there are many people who, because of the extent of

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## PSYCHIATRY AND ANTI-POVERTY WORK (continued)

their mental illness, are not able to access the social services for which they are eligible, whether that be housing assistance or ODSP. So I would say that both physical and mental illness require a systemic perspective to treat.

JM: *You've mentioned ODSP several times. What I understood was that getting ODSP was a lot harder for those with mental illnesses and almost impossible for addictions. I don't know if you have any experience around that or any ideas about how to address it?*

MB: There remains so much prejudice in society, and addictions are often the most stigmatized; it is not uncommon to hear people equate addictions with moral failure, rather than seeing them as a complex and multifactorial illness. And it is only through recent court challenges that people with addictions are even eligible to apply for ODSP. In Toronto there are a few amazing psychiatrists and family doctors who have done tremendous work in setting up Inner City Health Associates and other programs that help people with mental illness, and those who are homeless, to apply for the benefits they are eligible for.

JM: *I am wondering if we can look at the implications for mental health policy in a broader sense. Do you feel there is a difference in how those with mental disability are viewed or able to access social services by comparison to those with more medical or physical causes of disability?*

MB: Absolutely, I think there's a difference, both at the provider level and at the policy level – it is only in recent years that people are even admitting publicly to having a mental illness, and that stigma carries over into policy discussions. But mentioning stigma once again brings me back to a consideration of the social determinants of health – often people are marginalized not only because they have a mental illness that may impact their ability to fit societal norms, but also because they don't have the basics that allow one to access the system. If you live on the street, or don't have enough money for new clothing, or are unable to access dental care – these things will all impact your ability to access social services.

But more importantly, I think the services provided for both groups are inadequate to meet the need. It is not only our patients who are sick – it is also the system itself that is ailing. We often hear people say that the most vulnerable in society are “falling between the cracks,” but we need to step back and ask ourselves, why do these cracks exist? For these gaps are created and upheld by the current economic system that privileges profit over people's health. We have seen drastic cuts in social welfare rates in the past decades, while at the same time there is increasing privatization of healthcare, which has been shown to be both more costly, and lead to worse health outcomes.

We work in an environment where people suffer not only because social welfare rates are dangerously low, but also because there is a lack of mental health services, and community services, across the board.

JM: *Do you have any ideas about approaches that can maybe short circuit some of the problems?*

MB: In terms of stigma, we need to look more towards harm reduction approaches. For example, in housing, there's a movement of “housing first” which is now being studied by the Mental Health Commission of Canada. Traditionally, you could not access mental health housing if you were still using substances, or if you weren't accepting treatment, which is a very patronizing approach. The housing first approach sees housing as fundamental to people's ability to recover. At the same time, I think we already know enough to say that housing is a fundamental right, and in Canada and particularly in Toronto, the lack of social housing is at a crisis level, with waiting lists up to 10 years. We need to see a commitment to building more affordable housing, especially housing that is located near people's communities, near transit, and near services. And we need to see increased investment in mental health services.

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## PSYCHIATRY AND ANTI-POVERTY WORK (continued)

JM: *If this is where you are likely to put your energy in the next five years, what will your work look like?*

MB: I still have a few more years of residency to go, and a lot to learn! For now, my work will be both within the residency program and as part of grassroots community groups. Within the residency, I try to create spaces to discuss the social determinants of health, the role of poverty in the lives of our patients, and to always bring it back to answering the question: what can we do? Part of the answer is that as a society, what we need to do is address inequality. We're hearing the word "austerity" being used a lot and we're seeing the impacts of austerity measures globally. And in Canada as well we are starting to see more cutbacks in social spending. This is something we need to be prepared for, as a health sector. At the same time, it's not as if there isn't enough money. We're seeing increasing budgets for security, a billion dollars spent on the G20, money for the continued occupation of Afghanistan, an intended \$16 billion for attack aircraft, and yet we're being told that there's no money for the Special Diet allowance for people to eat healthy and nutritious food, or that there's no money to build more housing so that people can live in safety, or that there's no money so that people can get an education. There is really a disjuncture between these two narratives, and we need to speak up and challenge our governments on the choices they are making. We know that poverty is not cost effective—poverty costs us as a society and leads to worse health outcomes. Both Ontario Works and Ontario Disability Support were drastically cut back in the Harris years and every year since then the rates have failed to keep up with inflation. Inequality continues to grow in our society, and it those with mental illness, those already marginalized, who are being affected the most by the austerity agenda.

So I will continue to advocate in solidarity with people for an increase in the social welfare rate, for improved housing, for access to mental health services, for full immigration status for all people, for access to healthy food, for the essential building blocks that will lead to health for all, both locally and internationally.

JM: *So what do you think your work is going to look like in five years?*

MB: I don't know. I see myself doing a mixture of clinical work with people because I really enjoy that. I think it's important to remain connected to people, as well as to do community organizing where I think we have room to be much more critical. At the same time, it's important to bring a critical lens into the academy, into research, into medical education, and into the policy sphere. So I don't have details of what that will look like, but I definitely see myself continuing along this path. I've got a lot to learn.

JM: *What do you think others in the health professions can/should do to assist?*

MB: I think we need to start by listening to our patients, and listening to the stories that they tell us, the situations they're living in, because they're the ones with the experience. We need to think more about what recovery can mean, what it means to live a healthy life, and how the work we do can support people, in a non-coercive way. And we need to learn to think about the way the system is structured, and how our actions either support or challenge that structure.

We also need to start looking at ourselves; as physicians we're an elite profession, we're used to a certain income and status, and it can be professionally risky to challenge the system that we operate in, a risk that won't go away until we reach a critical mass. We already know where the gaps are, and what needs to change isn't really arbitrary or unknown or mysterious. We know where the gaps are and we know how to fix them as well.

One avenue that people can play a role in is within our professional organizations. We have the Canadian Medical Association which this year is being led by Dr. Jeffrey Turnbull, who has worked with people with mental illness, and people living in poverty. We need to continue to support people like Jeff, a role that the MRG has taken on.

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## PSYCHIATRY AND ANTI-POVERTY WORK (continued)

At the same time, we need to continue to put pressure on our provincial and national governments to eliminate poverty.

At the clinical level, as psychiatrists we need to continue the work of shifting to a recovery based model, that includes people with experience of mental illness and poverty both in clinical work and in decision making. And when conducting research, we need to work harder to include people with direct experience from the very beginning of developing projects, because they're the ones who have the experience. As health providers we're often quite removed from the day to day reality of poverty that people live in, and we need to become aware of our blind spots.

Working together with community groups is important, to expand the base of people who are aware of the impact of poverty. We have a fight on our hands in terms of eradicating poverty, it's not that it's not doable, it's that the commitment to change isn't present at the top and will need to be created from the ground up. I think that working as health providers, we definitely have a role to play in bringing issues of marginalization to the forefront.

And finally, it's really important to maintain a focus on health, and not just on health care services. We are incredibly lucky to have the system we do in Canada, but it is continually being eroded by the threat of privatization, and there remain many people who cannot obtain care. Thinking about health more broadly can help us understand where to focus our energies. I like the definition of health from the People's Health Movement, which sees health is as a social, economic and political issue and above all a fundamental human right. ♦

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## ONTARIO POVERTY REDUCTION STRATEGY UPDATE

*Janet Maher*

When then Minister of Children of Youth (now Health and Long Term Care) Deb Matthews launched the Ontario Poverty Reduction Strategy in December 2008, many activists had high hopes her leadership would help raise all boats, despite the main target of reducing the number of children in poverty by 25 per cent over the full mandate of the government.

To the government's credit, they have kept the promises they made, though not necessarily all the promises activists have lobbied for. In late November, the current Minister of Children and Youth, the Hon. Laurel Broten released a second annual progress report. The report summarizes achievements which included:

- Accelerating the Ontario Child

Benefit which now provides up to \$1,100 annually per child to low-income families;

- Increasing the provincial minimum wage to \$10.25 an hour;
- 'Saving' 8,500 child care spaces that would have disappeared in the province as a result of a federal funding gap,
- Expansion of full day kindergarten to 4- and 5-year-olds in some of the most vulnerable neighbourhoods.

In addition, allied ministries have made some additional investments, for example, in a preventive dental program for children, and commissioned an advisory panel on social assistance, and a long-term affordable housing strategy. They have as well worked with other departments and the federal government on a program of tax measures which

will keep money in the pockets of low and moderate income families.

The November 2010 announcement acceded to the recommendations of the review panel appointed in 2009, to commission a more comprehensive review of income security and social assistance, focused on improving employment outcomes, improving fairness and reducing barriers. That program will be led by the former chief of Statistics Canada Dr. Munir Sheikh and the past president of the United Way of Toronto, Frances Lankin. The review will not be complete by the time of the October 2011 election, but would if the Liberals have their way provide the kind of blueprint offered by Judge George Thomson in 1988 [and described in MEDICAL REFORM issue 149].

*(continued on page 11)*

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## ONTARIO POVERTY REDUCTION STRATEGY UPDATE (continued)

In October, 2010, almost 400,000 Ontarians were receiving Ontario Disability Support Program Benefits and a little over 400,000 men, women and children were receiving short term welfare through Ontario Works. While the programs described by Broten and Community and Social Services Madeline Meil-leur will go some way to assisting ODSP and Ontario Works recipients with children, it does little for the 20 to 25 per cent mainly single and older adults outside the labour market who neither have children nor earn enough to take advantage of most of the tax measures and have consistently been left behind when overall social assistance rates have continually lagged behind inflation, so that the government can make the targeted investments in children. For

some of them the Special Diet Supplement had been a lifeline, in cases in which their health care providers could document conditions which would qualify for the allowance.

The Special Diet Program, however, has had a troubled existence in recent years in the Ministry of Community and Social Services. The 2009 Auditor General report which reported on serious administrative problems with the Special Diet Program (that is, predominantly bureaucratic errors). In early 2010, the Ontario Human Rights Commission rendered decisions on a series of human rights complaints by social assistance recipients, and found the government had discriminated against the complainants; an announcement was expected by the end of 2010 to address those complaints.

In the spring of 2010, now Toronto mayor Rob Ford filed a third party complaint against a Toronto doctor who he alleged was misusing the program. The Minister and her staff jumped to action with threats to discontinue the program in its entirety, but they have since backtracked somewhat, by proposing to maintain the program pending the completion of the Shaikh-Lankin review, but to tighten the eligibility rules. ♦

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## HEALTH CARE EXPERTS PROPOSE NEW WAYS TO PUBLICLY FUND HEALTH CARE

A new analysis proposes that governments consider several novel options for increasing revenues to fund medically necessary health care.

“Health care costs have increased over the last 50 years and they will almost certainly continue to do so,” said Dr. Ritika Goel, a spokesperson for the Medical Reform Group. She added: “While we need to ensure that the system is maximally efficient, we also need to figure out how governments can raise more money for health care.” “Canadians cherish the principle that access to health care should be based on need and not wealth. We should judge any mechanism to raise funds by criteria that include fairness,” said Goel.

In the article, published today in the Canadian Medical Association Journal, three physicians and an economist note that generating revenue by increasing income tax rates is both fair and efficient but advocating for higher taxes might be an unpopular strategy among elected officials. Other ways to generate revenue include taxes on unhealthy foods, earmarked taxes for health care and removing the government subsidy on private health insurance.

“Removing the private health insurance subsidy would raise a lot of money,” said Dr. Goel. “This could start paying for a national Pharmacare program,” she added. “Taxes on sugary soft drinks and very unhealthy foods have been implemented in other countries and have a dou-

ble benefit -- they promote healthier food choices and they result in more money to spend on health care.”

The authors of the new paper are Dr. Irfan Dhalla and Dr. Ahmed Bayoumi from St. Michael’s Hospital and the University of Toronto, Dr. Gordon Guyatt from McMaster University and Professor Mark Stabile from the Rotman School of Management and the School of Public Policy at the University of Toronto. Dr. Guyatt and Dr. Bayoumi also serve on the steering committee of the Medical Reform Group; Dr. Dhalla is a member of the Medical Reform Group and a former member of the steering committee. ♦

*Released by the Medical Reform Group  
November 29th, 2010.*

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# WHAT CAN BE BETTER IN CANADA'S HEALTH CARE SYSTEM

*An opinion contribution on health care access and equity by Ahmed Bayoumi*

**T**he Commonwealth Fund has updated its ranking of health care systems. According to this fund, we have a better health care system than the United States. We do very well when all determinants of health are considered, coming in second in the “Long, Health, and Productive Lives” category. But overall, the other advanced market economy countries included in the ranking (Australia, Germany, Netherlands, New Zealand, and the United Kingdom) did better than Canada. That means we finished 6th of 7, which should cause all of us to pause and think for a moment.

Where can we do better? Canada ranked last in terms of quality of care. While we did pretty well on questions such as whether the doctor asked about emotional problems (3rd place) or whether patients received advice about weight, nutrition, and exercise (2nd place), we were far behind all countries on questions about basic computerization (being able to print out a list of patients, sending

reminders, printing out lists of patient medications). Indeed, almost all of the quality of care and efficiency indicators where Canada did badly focus on information systems or coordination of care.

While Canadians pride themselves on prioritizing access to care with Medicare, the Commonwealth Fund report indicates that we did relatively well in minimizing cost-related access issues but lost many marks in terms of timeliness of care.

Finally, Canada gets mid-range marks when it comes to equity measures for health but poor marks, not surprisingly, when it comes to equity in dental care or prescription drugs. Of patients with below-average incomes, one-third did not see a dentist even though they needed one because of the cost and one-fifth skipped doses or did not fill a prescription because of cost.

Of course, there are problems with such rankings. Many of the indicators are based on surveys of patients and physicians, which

are prone to reporting biases (both perceptions and willingness to report long waiting times might be influenced by media reports, for example). It's not always clear that the indicators are equally important. Some of the data is a few years old. And it is not possible using these data to differentiate between provinces to see if province-specific initiatives to reduce waiting times have been effective. Nevertheless, the results are useful in that they remind us of the importance of constant evaluation and of the importance of international (not only U.S.) comparisons. The results are also instructive and clearly point to areas that others have identified as needing improvement – coordination of care and better communication, basic information systems, continued attention to waiting lists, public dental care, and universal pharmacare. Notably, none of these indicators would improve by establishing a parallel private system. ♦

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## FOR ALL OUR SAKES, BC MUST REVERSE COURSE ON DRUG REVIEW POLICY

*An opinion contribution to the debate on BC proposals to scrap a model drug review policy by Gordon Guyatt, Joel Lexchin, and Patricia Baird*

**N**owadays, the public discourse is rife with expressions of concern about rising health care costs. Although the language of crisis often goes substantially beyond the reality, there is no question that Canadian health care spending represents – as it does for every industrialized country – a major challenge. Calls for enhancing the efficiency of health care delivery

are therefore both appropriate and timely.

Spending on prescription drugs represents an excellent target for achieving greater efficiency. Drug spending is the one area in which the reality approaches the imagery of out-of-control exploding costs. In the last 10 years, spending on prescription drugs in Canada has increased 73.7% per capita, infla-

tion-adjusted. Although the picture is similar across the industrialized world, growth in prescription drug spending is rising more quickly in Canada than any other developed country.

Polypharmacy is the order of the day. By retirement age, few Canadians escape the apparent requirement for drug use for prevention, or

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## BC MUST REVERSE COURSE ON DRUG REVIEW POLICY (continued)

therapy, or both. From antibiotics to sedatives to anti-inflammatory agents, Canadian doctors prescribe more drugs, and particularly more expensive drugs, than is necessary.

The convergence of these factors has helped turn the makers of prescription drugs into one of the largest, most profitable and most powerful industries in the world. The industry further inflates its profits through unsavory practices including hiding or distorting unfavourable evidence and spending large sums on expert physicians to influence their views and statements. One result has been that an ever-increasing number of people are exposed to drugs that have dangerous adverse effects and ultimately need to be pulled from the market.

However, there is enormous scope for governments to reduce public spending on drugs and promote safe use of medications. Prescription drug spending greatly varies both internationally, and in Canada. British Columbia has the lowest average per capita spending, \$432, while Quebec, the spendthrift province, comes in at \$681.

How has BC limited pharmaceutical costs and kept its citizens relatively safe from harmful effects of prescription drugs? First, they have introduced reference-based pricing, in which the government will pay only for the least expensive, equally safe and effective drug in a particular drug class.

Second, they limited industry influence over which medications the provincial drug plan will cover. Up until now, the province has relied on independent, evidence-based reviews by a University of British Columbia-based group, the Therapeutics Initiative, to guide its funding decisions.

The TI has earned a reputation as a rigorous, critical reviewer of drug benefits and risks. The group's investigation of Vioxx, an anti-inflammatory drug that for some time gained huge success in most markets, revealed evidence of an increase in heart attacks and other serious adverse events with the drug. As a consequence, BC PharmaCare delayed the decision to fund Vioxx. Eventually, in response to industry pressure, funding was granted, but with restrictions as a third-line drug. TI warnings proved prescient, and the delay and restrictions on drug use indirectly saved an estimated 500 lives. In the end, Vioxx proved to be so dangerous that it needed to be removed from the market.

But now, just when health advocates are suggesting other provinces replicate the BC model, the BC government is dismantling it, and reverting to older, less efficient ways of doing business. At the behest of a review dominated by brand-name pharmaceutical industry influence, the government is eliminating the Therapeutics Initiative's role in evidence-based reviews.

Furthermore, the BC government is handing more control over the process to industry by implementing a new procedure for deciding what drugs go on BC's public formulary. That procedure includes four separate "sponsor engagement points" during the review process, engagement that will inevitably increase industry influence on funding decisions.

Why is the BC government taking such apparent retrograde steps? They argue that increasing industry influence over the decision process will lead to effective medication coming to the market more quickly. However, fewer than 1% of

new drugs are breakthroughs. Most new drugs are "me-too" offerings with minimal or no additional benefits but merely an opportunity for companies to try to grab a share of lucrative markets. Real innovations when they appear, are not difficult to identify.

Moreover, recent experiences with drug withdrawals due to serious unanticipated adverse effects suggest the need for caution. In the absence of a breakthrough with clear large benefits, Canadians are best served by a conservative policy of delaying public drug funding until the benefit to harm ratio is better understood.

Just when it is needed most, a model that ensures efficiency of a beleaguered system of public funding of health care delivery is in danger of disappearing. For all our sakes, let's hope that new leadership in the province signals the possibility of re-instituting the role of the Therapeutics Initiative, and reversing its costly, retrograde course. ♦

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# PRIVATE HOME CARE DEMAND ON THE RISE

Denise Dary

*The Ontario Health Coalition released a landmark report on home care in the fall of 2008 and will shortly be releasing a new report. This recent story (November 16, 2010) from the Hamilton Spectator highlights some of the most conspicuous gaps in our current home care 'program'. As the government continues to push for us to do more with less, the privatization of home care expands and the burden on patients and their caregivers worsens. In many areas, local hospitals are cutting services at the same time as admissions to home care are being curtailed to meet budget requirements.*

Maureen Baldry's 34 year old son Ryan Sparks has MS and needs round the clock support care. She has daytime PSW's from CCAC as well as private home care to enhance the services she gets.

Maureen Baldry considers herself one of the lucky ones.

She receives 42 hours of home care per week from the Community Care Access Centre (CCAC) for her son Ryan, 34, who has multiple sclerosis and is blind and must be tube fed.

Five mornings a week a nurse also comes in from a private home health care service which costs her \$800 a month. It's a financial strain but it's early morning care that's difficult to find through the CCAC and it allows her to get to her job at the Hamilton-Wentworth District School Board office on time.

The 42 hours of services she receives from the CCAC are well below the 90 hours allowed. She would also love to have help on evenings and weekends.

Still, she says: "I feel like I'm really lucky with the stuff that I get. There are people in my MS support group who maybe get three hours a week."

Patching together services from the CCAC, as well as private home health care agencies, is becoming more the norm as families struggle to help ailing family members stay in the home.

The demand for home health care has been growing since the Ministry of Health and Long Term Care increased the cap on home care to 90

hours a month from 60 hours about a year and a half ago.

While the new cap pushed up the demand for services provided by CCAC, funding to provide those services failed to keep pace.

Yvonne Griggs, chief executive officer of Alert Best Nursing and Home Care Solutions, said they've seen a 50 per cent increase in the area of staffing and home care since the new policy came into effect. Families pay almost \$24 an hour for a personal support worker who does meal preparations and help clients, who are mostly elderly, with bathing, exercises, and walking.

"If they don't get enough hours from the CCAC we top them up," Griggs said.

The local CCAC, which oversees home care and long-term care, is so overwhelmed by demand for home-care services they're carrying a \$5-million deficit on their \$233-million budget.

Barbara Busing, senior director of client services for the local CCAC, said they're experiencing increased demand for home and community care services, both in terms of the number of people needing service and in the intensity of the service.

"Many of our clients have more complex needs than ever before," Busing said. "Serving those with the greatest need within our funding envelope is a complicated balancing act."

Provincial health critic Christine Elliott said the provincial government has been pushing health care away from hospitals and toward

home care services for years but are still failing to provide adequate home care services.

Elliott said it's creating a two-tier system where those who can afford more services get better care.

"What's happening in Hamilton is indicative of what's happening across the province. CCACs are being overwhelmed with requests for service," Elliott said. "The whole situation is becoming rapidly worse. This is a group of people who deserve much better than what they're getting."

"A lot of times we help them find out what else is available."

Griggs said people sometimes call them who aren't even aware of the CCAC's services.

"Sometimes — a lot of times — they don't even know what's out there. They're discharged from the hospital with nothing in place. It's grim. Sometimes they're on the verge of a nervous breakdown by the time they call us."

Minister of Health Deb Matthews insists more money is being funneled into home care and said there is "absolutely no truth to the suggestion that there is a cut to the funding. It's quite the opposite. There's been an increase and they will be getting more this year."

Matthews said the province invested \$93 million into the Aging at Home strategy and that they're focusing on community supports as a way to help people remain in their homes.

*Reproduced from The Hamilton Spectator, November 16, 2010. ♦*

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# 2010 ONTARIO AUDITOR GENERAL FOCUSES ON HEALTH CARE GAPS

Janet Mabey

**L**ike his federal counterpart, Ontario Auditor General Jim McCarter has been moving to focus on value-for money audits, and this year noted on the release of his 2010 report that because of the proportion of the provincial budget dedicated to health care, spending in that sector was a natural place to start.

Among his findings:

- Long wait times in hospital emergency rooms had as much to do

with delays in freeing up in-patient beds as with a lack of specialist services or patients walking into ERs with minor ailments.

- More than 50,000 hospital patients who could have been discharged endured longer than necessary stays in 2009 because of the time it took to line up their post-discharge care.

- The province tends to fund home care services based on historical allocations rather than on an

assessment of current client needs, creating a risk that people with identical needs get varying levels of service depending on where in the province they live. ♦

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