# Medical Reform

*Newsletter of the Medical Reform Group*

Issue 156 Volume 31, Number 3 Winter 2012


# PROGRESS IN EVIDENCE-BASED MEDICINE -- WHAT WE HAVE LEARNED IN 20 YEARS

*This issue, we look back on a generation in the evolution of evidence-based medicine with Gordon Guyatt, one of the key players whose work was recently recognized in his appointment as an Officer of the Order of Canada.*

**Q**: Now that Evidence Based Medicine has been with us for nearly 20 years, I wonder if you can help us assess its impact. Can you begin by giving some of the background?

**A**: Well, the term arose when I took the position of Director of the Internal Medicine residency program at McMaster University and needed a term to describe the - in our view - new approach we were taking to postgraduate medical education. The term I chose, evidence-based medicine (EBM), proved propitious. The term, and the concept, didn't impact the wider world until the 1992 publication in JAMA of an article by the Evidence-Based Medicine Working Group focusing on the role of evidence-based medicine (EBM) in medical education. Although the term evidence-based medicine first appeared in the published literature the prior year, the JAMA publication really brought both the label and the underlying philosophy to the attention of the general medical community.

The article was audacious in suggesting that EBM represented a new paradigm in the teaching and practice of medicine, by deemphasizing unsystematic clinical observations, pathophysiological inference, and authority. It honoured traditional skills (for example, understanding biology, demonstrating empathy), but emphasized new skills that learners must acquire and use: question formulation, search and retrieval of the best available evidence, and critical appraisal of the study methods to ascertain the validity of results—in short, the article aggressively presented EBM as a fundamentally new approach.

**Q**: Can you talk a little about your strategies in promoting the uptake of EBM?

**A**: Well, an important set of tools consisted of the Users' Guides to the Medical Literature series in JAMA that quickly followed the 1992 article. They provided tools for learners and teachers to hone their skills in appraising and applying results of studies focused on questions of therapy, diagnosis, prognosis, and harm. Eventually the series addressed 25 separate topics, and helped readers understand the value of systematic reviews, decision and economic

*(continued on page 3)*

## INSIDE



*Please visit our website at: http://www.medicalreformgroup.ca*

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

Articles and letters on health-related issues are welcomed. Submissions should be typed, or sent by e-mail to medicalreform@sympatico.ca.

Send correspondence to:
**MEDICAL REFORM**
Box 40074, RPO Marlee
Toronto, Ontario M6B 4K4.
Telephone: (416) 787-5246
Fax: (416) 352-1454
E-mail: medicalreform@sympatico.ca

Opinions expressed in ***MEDICAL REFORM*** are those of the writers, and not necessarily those of the Medical Reform Group.

Editorial committee this issue: Ritika Goel, 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*

Unlike a lot of the other provinces, Ontario emerged from the fall election with a minority Liberal government which may prove a potent antidote to the federal Conservative majority, at a minimum in facilitating a broader public debate than might otherwise happen. This seems particularly important in the context of an economy which appears to be more and more vulnerable to international crises, regardless of the much-vaunted strength of some of our financial institutions.

The Ontario parties are still jockeying for space, and it will be important to be vigilant in the coming weeks as the province prepares its budget for the coming year and the federal provincial health and finance ministers begin to seriously sink their teeth into the reformulation of the 2004 Federal-Provincial-Territorial funding accord when the federal finance minister has already warned that the 6 per cent escalator which defused concerns in the 2011 election will be phased out as of 2015-16. In early December, many Canadian Health Coalition members organized a Parliament Hill lobby on the principles of the Call to Action signed by supporters across the country, and included in this issue.

This issue of MEDICAL REFORM features an interview with Gordon Guyatt assessing the evolution of 20 years of evidence-based medicine and its contributions to clinical practice and health policy more generally. A further contribution from member Ritika Goel on her review of the role of pharma in physicians' prescribing behavior.

As noted in the review by the 25 in 5 Network of the first 3 years of poverty reduction in Ontario, with few exceptions, life for the most vulnerable has gotten worse not better. With miniscule increases in the cost of living allowances for single adults over the past 16 years, the monthly maintenance allowance has actually declined in value from the 'bad old days' when then Premier Mike Harris rolled back rates by almost 25 per cent. At the same time, the province can claim that policy has made a difference as some 20,000 children have been lifted above the poverty line by the enriched Child Tax Benefit.

In early December, the Ontario Auditor General released his annual report, which includes some updates on the Ontario Works audit recommendations from 2009. No new results are reported on the 2009 allegations of fraud and inappropriate use of certain supplementary allowances, including the Special Diet, but a number of the auditor-general's comments indicate that this is an area that continues to bear monitoring. Administrative policy changes, in the form of requiring potential recipients to authorize the release of private information and changes in risk management strategies are expected to assist in 'managing' issues identified by the provincial auditor general pending a major policy review announced in late 2010 and the implementation of an upgraded informatics system.

Perhaps most gratifying of all was the response of members to our October release supporting the Occupy movement in which protesters across the country who focused attention on the continuing problems with an economic system that enhances rather than reduces inequalities. For a few months, a real space has emerged for discussion of the role and value of public services and adequate taxes to support them. ♦

analyses, and practice guidelines in particular.

Courses on how to teach EBM, popular books on the subject, related series in medical and surgical specialties; and enthusiastic uptake by junior faculty (mostly in general medicine), students, and trainees followed. The term EBM proved extraordinarily popular and is now widely used in related health fields (for instance, evidence-based health policy, evidence-based nursing). The influence of EBM has been widely recognized both in lay publications and in the academic press. The New York Times listed EBM as one of its ideas of the year in 2001, and the BMJ listed EBM as one of the 15 greatest medical milestones since 1840. An important advance since the recognition of EBM has included enormous advances in ease of accessing and understanding information, the development of preprocessed evidence-based information, and the increasing emphasis on patients' values and preferences in clinical decision making.

**Q**: Can you give an example for the lay person?

**A**: Sure, I think we can point to the development of the Internet which has made finding and retrieving original articles much easier. Emblematic of this effort is the pioneering work of the National Library of Medicine in developing and maintaining the MEDLINE database. Users often access this database from its own interface, PubMed, but also from Internet search engines like Google, and from commercial MEDLINE interfaces (for example, OVID).

These search and retrieval interfaces have improved with the development of "hedges," that is, search strategies that retrieve articles with optimal sensitivity and precision,[5] and by linking the title and abstract to the full-text publications and related documents.

Clinicians and other learners benefit not only from these "pull" services, but also from services that electronically "push" selected evidence screened for quality, newsworthiness, and relevance to the user. I am thinking here of services produced by the McMaster Premium Literature Service [PLUS] such as the ACP Journal Club Plus. A key benefit of some of these push services is the rigorous pre-appraisal of evidence. For instance, the ACP Journal Club not only highlights selected articles with high methodological quality and potential relevance but also offers structured abstracts that document methodological quality criteria, which allows readers to evaluate the validity of the results very easily. In addition, these services present pertinent results transparently and offer independent commentary.

I think the dissemination of systematic reviews of primary studies, which was gaining credibility at the time of the EBM publication has also helped clinicians integrate all of the best available evidence addressing a particular clinical problem. Systematic reviews have demonstrated the limitations of basing practice on the most salient, most recent, or most popular study. The Cochrane database now includes more than 3,500 systematic reviews and the Cochrane Collaboration has played a crucial role in advancing the science of knowledge synthesis.

Moreover, other electronic resources represent a revolutionary change in gathering and summarizing evidence and making recommendations—a change driven largely by EBM. Resources like PIER, BMJ-Clinical Evidence, and UpToDate, which make use of the pre-appraised resources I have just talked about increasingly bring evidence explicitly and practically to the point of care. This is a developing area, and decision support systems that embed such summaries in the medical record and the clinical workflow are still evolving.

**Q**: Are there developments on this model or paradigm that we should know about?

**A**: The initial areas of focus for EBM were the identification, critical appraisal and summarizing of evidence. However, as the 1992 article had hinted, evidence alone is not sufficient to make clinical decisions. So, in 2000, the Evidence-Based Medicine Working Group presented the second fundamental principle of EBM (the hierarchy of evidence being the first)--whatever the evidence, value and preference judgments are implicit in every clinical decision.

A key implication of this second principle is that clinical decisions, recommendations, and practice guidelines must not only attend to the best available evidence, but also to the values and preferences of the informed patient. Values and preferences refer not only the patients' perspectives, beliefs, expectations, and goals for life and health, but also the processes individuals use to consider the available options and their relative benefits, harms, costs, and inconveniences. Since 1992, the landscape has changed substantially, with much work in the fields of shared decision making, patient decision support technologies, the evolution of the patient rights movement, and the Internet-enabled democratization of technical information in medicine as elsewhere.

Recently, the first National Health Service Constitution in Great Britain suggested that patient par-

*(continued on page 4)*

ticipation in decision making is a patient's right; in the United States, the Institute of Medicine designated evidence-based patient-centered health care delivery as a key feature of high-quality medical care.

Another important evolution of EBM has been the development of the Grades of Recommendation Assessment, Development and Evaluation (GRADE) framework. The pioneering work of Eddy was important in strengthening the evidence base of clinical practice guidelines even before the 1992 EBM article. The Evidence-Based Medicine Working Group initially focused on the relationship between individual clinicians and the application of the original literature to clinical care. Recognition of the importance of pre-appraised resources and guidelines has led the EBM movement to a greater focus on the methodology of applying EBM principles to management recommendations.

The GRADE Working Group has developed a framework for the formulation of treatment recommendations that is based on the contemporary principles of EBM. The GRADE process represents an important evolution in EBM and highlights the importance of clear specification of the question with the identification of all patient-important outcomes and the necessity for systematic summaries of all the best evidence to guide recommendations. The definition of quality of evidence and the components that determine quality, including study design and study limitations, consistency, precision, and the extent to which the evidence directly applies to the patients, interventions, and outcomes of interest are all part of that evolution.

The GRADE framework requires the specification of values and preferences in making recommendations and demands attention to circumstances, and resources for competing priorities in deciding how confident one is that following a recommendation will do more good than harm. This system produces either strong recommendations that provide ideal targets for quality improvement efforts, or weaker recommendations that identify ideal targets for careful incorporation of patient preferences for example, using decision aids in practice.

So I think it can be said that a new paradigm for medical practice is emerging. Evidence-based medicine de-emphasizes intuition, unsystematic clinical experience, and pathophysiologic rationale as sufficient grounds for clinical decision making and stresses the examination of evidence from clinical research. Evidence-based medicine requires new skills of the physician, including efficient literature searching, application of formal rules of evidence evaluating the clinical literature, and ensuring that decisions are consistent with patients' values and preferences.

**Q**: I hear a lot these days about EBM, or evidence-informed medicine, which appears to be a slightly less rigorous application of the EBM principles; many times this sounds a little like a mantra invoked by some clinicians for whatever they are doing. Do you want to comment on that?

**A**: Well, an analogy can be made between EBM and nuclear fission: it can be very powerful when used appropriately and dangerous when used inappropriately. The term evidence-based precedes many recommendations, guidelines, and algorithms that are not transparently linked to the underlying evidence base and do not represent the results of a systematic and critical appraisal of that evidence. It sometimes appears as if using the term obviates the need to describe the quality of underlying evidence, the magnitude of effects, or the applicability of any of the results in the context, values, and preferences of the patients.

This is particularly problematic because the EBM era has coincided with a dramatic increase in the for-profit funding of research. Researchers funded by industry interpret their results differently and in favor of the industry product relative to not-for-profit funding. Problems associated with industry funding include use of inappropriate control interventions, surrogate outcomes, publication and reporting bias, and misleading descriptions and presentations of research findings—all forms of corrupting the evidence base. Unsophisticated users of the medical literature, assuming that medical editors, peer reviewers, and topic experts have now become familiar with the tenets of EBM, may trust these corrupted research reports and advocate for their application in practice.

Many medical schools and training programs, in a form of premature closure, are moving away from teaching the fundamentals of careful evidence appraisal to emphasize the implementation of evidence. The intent of this new focus is to produce high-quality, safe, and low-cost care, as in the Accreditation Council for Graduate Medical Education competencies of systems-based practice and improvement and practice-based learning. However, abandoning appropriate skepticism regarding the effectiveness of these interventions may lead to large investments in quality-improvement, safety, and efficiency activities that fail to yield the

*(continued on page 5)*

expected benefits.

I believe EBM continues to have a substantial potential for the increasing the production of high-quality studies that address important questions using optimal study designs and large sample sizes, and the unbiased, meticulous summarization of the best evidence. Achieving this goal is crucial in a world moving hurriedly toward molecular medicine. Clinicians and researchers who understand the EBM approach and tenets will look beyond the novelty, and deal with the special challenges that arise from the use of information from molecular diagnostic and prognostic tests and from treatments linked to these technologies. EBM remains the fundamental framework for investigators intent on conducting translational research from clinical research to clinical practice.

When based on EBM principles, quality improvement science can realize the reliable application of evidence and make health care a high-value proposition. With the emergence of the electronic medical record, many see opportunities in the use of practice-based information to make inferences regarding treatment effectiveness and recommendations based on these inferences. However, it is essential to remember the perils of ignoring the hierarchy of evidence and abandoning awareness of the biases associated with observational studies. The medical community must resist the temptation to use information accrued in practice based on choice rather than chance to assess treatment efficacy among patient subgroups. At the same time, these information sources will likely prove valuable in detecting rare harms and unintended consequences of clinical actions.

Reliance on easily obtained but potentially misleading evidence and the increase in commercial interests to produce and interpret evidence for physicians will remain potent. The appropriate application of EBM will continue to provide safeguards against these dangers. Clinicians will enjoy a set of increasingly accessible sources of evidence, evidence summaries, and guidelines that acknowledge the most current EBM thinking—perhaps best captured in the GRADE system—and in particular the role of values and preferences in decision making. Medical and health policy training must continue to evolve, allowing clinicians and policy makers to successfully differentiate truly evidence-based sources of information and interpretation of information, from those that are not.

**Q**: Some of the advantages are, as you note, clear. I wonder if you can finish off our conversation by speaking to the need for evidence to inform advocacy as well as policy, given the high emphasis on research and evidence in medicine?

**A**: I believe in evidence-based health policy as strongly as I do in evidence-based medical practice. For years, my colleague PJ Devereaux and I have been advocating a move away from ideology and toward evidence as a basis for making health policy decisions. Our own foray into this area has been a series of systematic reviews that provided moderate quality evidence that for-profit hospitals and for-profit dialysis facilities have higher death rates than not-for-profit hospitals and dialysis facilities, the for-profit hospitals cost more than not-for-profit hospitals, and that for-profit nursing homes provide poorer care than not-for-profit nursing homes. Fortunately, this is not the only area in which the evidence supports the positions taken by the Medical Reform Group. As Roy Romanow concluded, universal medical care is as affordable as we want it to be, and has advantages of not only equity but also efficiency. ♦

Some of the key documents in the development and evolution of EBM


1. Accreditation Council for Graduate Medical Education. Common Program Requirements. http://www.acgme.org. Accessed April 23, 2007.
2. Als-Nielsen B, Chen W, Gluud C, Kjaergard LL. Association of funding and conclusions in randomized drug trials: a reflection of treatment effect or adverse events? JAMA. 2003;290(7):921-928.
3. Avorn J. In defense of pharmacoepidemiology–embracing the yin and yang of drug research. N Engl J Med. 2007;357(22):2219-2221.
4. Committee on Quality of Health Care in America, Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academic Press; 2001.
5. Evidence-Based Medicine Working Group. Evidence-based medicine: a new approach to teaching the practice of medicine. JAMA. 1992;268(17):2420-2425.
6. Guyatt G. Evidence-based Medicine. ACP J Club. 1991;114(suppl 2):A16.
7. Guyatt GH, Rennie D. Users' guides to the medical literature. JAMA. 1993; 270(17):2096-2097.
8. Guyatt GH, Haynes RB, Jaeschke RZ, et al. Users' Guides to the Medical Literature: XXV: evidence-based medicine: principles for applying the Users' Guides to patient care: Evidence-Based Medicine Working Group. JAMA. 2000;284 (10):1290-1296.
9. Guyatt G, Rennie D, Meade M, Cook D. JAMA Evidence Users' Guides to the Medical Literature. A Manual for Evidence-Based Clinical Practice.


*(continued on page 6)*

# WESTERN MEDICINE: THE INFLUENCE OF THE PHARMACEUTICAL INDUSTRY ON PHYSICIAN BEHAVIOUR

*Ritika Goel*

In my few years in medicine, I've been amazed at the presence of the pharmaceutical industry in the lives of physicians. I've seen countless supervisors and colleagues approached by drug representatives with pearly smiles and shiny flow charts demonstrating the benefits of their marketed drug, often accompanied with a side conversation about the benefits of off-label uses. For those physicians that are skeptical of drug company evidence, they are usually still happy to accept drug samples as tokens to supposedly help their less fortunate patients. I've sat through countless lunchtime presentations where lunch was provided by drug companies and read articles in reputable journals where researchers have received substantial funding from drug companies. I've also noted an attitude of invincibility from physician colleagues and supervisors as to the ability of the pharmaceutical industry to penetrate their prescribing behaviour. Given all the discussion around health behaviour change in our patients, it seems worthwhile to determine how physician behaviour change occurs and what the pharmaceutical industry knows that we don't.

A national survey in the US conducted by Campbell et al. (2007a) on physician-industry relationships showed 94% of physicians reported some form of relationship with the drug industry with 83% receiving food in their workplaces and 78% receiving drug samples. 28% of physicians reported having received a payment from a pharmaceutical company for consulting, giving lectures or enrolling patients in trials (Campbell et al., 2007a). The evidence of this interaction also extends into academia. A national survey conducted of department chairs of the 125 accredited medical schools in the United States and the 15 largest independent teaching hospitals found that almost two-thirds of department chairs had some form of personal relationship with the pharmaceutical industry (Campbell et al., 2007b). Interestingly, more than two-thirds of department chairs felt having a relationship with industry had no effect on their professional activities (Campbell et al., 2007b). Similarly, a study of medical residents found 61% reported that drug promotions did not influence their own practice. However, they recognized the potential for conflict of interest, since only 16% of them felt this way about other physicians (Steinman, Shlipak, & McPhee, 2001).

Given the extent of interactions between physicians and the pharmaceutical industry, it is surprising to see physicians do not feel it impacts on their behaviour, and therefore crucial to know the quality of information exchanged and the potential outcomes measured on physician behaviour. A study analyzing statements by pharmaceutical representatives when meeting with physicians, by Zeigler, Lew and Singer (1995), found that 11% of the statements made were inaccurate, and all of the inaccurate statements were made in favour of their drug. A systematic review of studies funded by pharmaceutical companies found that these were less likely to be published suggesting lower transparency, and if they were published, they were more likely to have outcomes favouring the sponsor than were studies with other sponsors (Lexchin, Bero, Djulbegovic, & Clark, 2003). These

*(continued on page 7)*

## PROGRESS IN EVIDENCE-BASED MEDICINE (continued)

2nd ed. Chicago, IL: McGraw Hill Co; 2008.

10. Guyatt GH, Oxman AD, Vist GE, et al. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. BMJ. 2008;336 (7650):924-926.
11. Montori V, Guyatt GH. Corruption of the evidence as threat and opportunity for evidence-based medicine. Harvard Health Policy Rev. 2007;2007(8):145155.
12. Montori VM, Saha S, Clarke M. A call for systematic reviews. J Gen Intern Med. 2004;19(12):1240-1241.
13. UK Department of Health. National Health Services Constitution. http://www .dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance / DH_085814. Accessed August 21, 2008.
14. Wilczynski NL, Morgan D, Haynes RB. An overview of the design and methods for retrieving high-quality studies for clinical care. BMC Med Inform Decis Mak. 2005;5:20.

studies suggest there is certainly evidence of misleading information coming from industry sources, and perhaps this may influence prescribing behaviour.

An extensive review of studies by Wazana (2000) found clear evidence of the influence of interactions with the pharmaceutical industry on the behaviour of physicians (Wazana, 2000). The review showed that meetings with pharmaceutical representatives were associated with physician-initiated requests for addition of the company's drug to the hospital formulary, increased prescribing of the drug marketed to them, an increase in the cost of drugs prescribed, an increase in 'non-rational prescribing' and an overall decrease in generic drug prescribing (Wazana, 2000).

Despite all this evidence, a qualitative study that conducted focus groups with physicians found that while they understood the concept of conflict of interest, physicians still maintained favourable views of interactions with the industry (Chimonas, Brennan, & Rothman, 2007). Chimonas et al., (2007) discuss that physicians used a variety of denials and rationalizations to resolve their cognitive dissonance by denying responsibility for the problem, avoiding thought about the conflict of interest and reasoning that meetings with pharmaceutical representatives were educational and beneficial to their patients.

Dana and Lowenstein (2003) discuss the concept of 'self-serving bias' as one that happens at a subconscious level leading to a tendency to act in a manner that favours one's own position. As applied to physician perceptions and behaviours, they note physicians see less of a concern with receiving gifts in their own profession relative to others suggesting this unconscious bias (Dana & Lowenstein, 2003). Dana and Lowenstein (2003) conclude that policies dealing with conflict of interest operating on the assumption that bias in prescribing is intentional are inherently flawed. They suggest policies limiting the size of gifts that can be accepted, educational initiatives that can be attended and mandatory disclosure of interests are not helpful since they do not address that the bias is unconscious (Dana & Lowenstein, 2003).

Clearly, there is evidence to suggest extensive interaction between physicians and the pharmaceutical industry, an influence by these interactions on physician behaviour, and a suggestion that these biased behaviours may occur subconsciously and are in contravention to physician beliefs. These issues raise a need to look at potential societal impacts of these physician-industry relationships and how they affect cost, access and appropriate treatment for patients. Discussion is needed among physicians, patients and policymakers to both acknowledge this unconscious bias that occurs and determine how increased awareness can influence a change in these physician beliefs as well as informing more effective policies for curbing the change in behaviours. Perhaps then, the industry of Western medicines can finally stop distorting the practice of Western medicine.♦

**References**

Campbell, E. G., Gruen, R. L., Mountford, J., Miller, L. G., Cleary, P. D., & Blumenthal, D. (2007a). A national survey of physician–industry relationships. New England Journal of Medicine, 356(17), 1742-1750.

Campbell EG, Weissman JS, Ehringhaus S, Rao SR, Moy B, Feibelmann S, Goold SD. (2007b) Institutional academic industry relationships. JAMA: The Journal of the American Medical Association. 298(15): 1779-1786.

Chimonas S, Brennan TA, Rothman DJ. (2007). Physicians and drug representatives: Exploring the dynamics of the relationship. Journal of General Internal Medicine. 22:184-190.

Dana J and Loewenstein G. (2003). A social science perspective on gifts to physicians from industry. JAMA: The Journal of the American Medical Association. 290(2); 252- 255.

Lexchin J, Bero LA, Djulbegovic B, Clark O. (2003). Pharmaceutical industry sponsorship and research outcome and quality: systematic review. BMJ. 326; 1167-1170.

Steinman MA, Shlipak MG, McPhee SJ. (2001). Of principles and pens: attitudes of medicine housestaff toward pharmaceutical industry promotions. The Americal Journal of Medicine. 110:551-557.

Wazana, A. (2000). Physicians and the pharmaceutical industry. JAMA: The Journal of the American Medical Association, 283(3), 373-380.

Ziegler MG, Lew P, Singer BC. (1995). The accuracy of drug information from pharmaceutical sales representatives. JAMA: The Journal of the American Medical Association. 273:1296–1298.

# SAFE INJECTION SITE DECISION: TRIUMPH OF EVIDENCE OVER IDEOLOGY

The Medical Reform Group (MRG) today hailed Canada's Supreme Court decision ordering the Harper government to exempt drug users and staff at the Insite clinic in Vancouver from drug-related prosecution.

"Too often, ideology trumps evidence in health policy decisions," said MRG spokesperson Dr. Gordon Guyatt. "The Harper government dismissed compelling evidence of the public health benefits of the safe injection site. We applaud the Supreme Court for insisting on evidence-based health policy."

In making its decision, the Supreme Court acknowledged the evidence suggesting that the Insite clinic improved the health of addicts and reduced deaths from overdoses without increasing crime and drug use in the surrounding area"

This is truly a landmark decision," said another MRG spokesperson, Dr. Michaela Beder. "Not only does it mean that Vancouver's Insite will stay open, but it will provide the opportunity for similar programs in larger Ontario cities, like Toronto, Hamilton and Ottawa, and the opportunity take advantage of the public health benefits," she added.

The ruling also sets a possible welcome precedent for the use of evidence in other health policy decisions.

"Debates over for-profit versus non-for-profit health care have largely ignored the compelling evidence that for-profit hospital and dialysis care increases death rates while costing third party payers more," Dr. Guyatt noted. "Furthermore, nursing home quality of care is superior in not-for-profit versus for-profit facilities. If government decisions can be evidence-drive rather than ideology-driven, the public will benefit. Perhaps in the future, it will not require a Supreme Court decision to ensure evidence-based health policy."♦

*Released by the Medical Reform Group October 3, 2011*

# SECURE THE FUTURE OF MEDICARE: A CALL TO CARE

*Canadian Health Coalition members and supporters, including the Medical Reform Group, signed on to this Call to Action in preparation for the December 1st, 2011 Lobby Day on Parliament Hill*

Health care in Canada is a fundamental right without distinction of race, gender, age, religion, sexual orientation, political belief, immigration status, and economic or social condition. Organizations representing millions of Canadians will mobilize to defend this right and to ensure that the following principles shape the direction of the Health Accord renewal:

1. The recognition of the highest attainment of health as a fundamental right throughout life and the necessity of preserving public health through active measures of promotion, prevention, and protection including such determinants as housing, food safety, income, education, environment, employment and peace.

2. The recognition that many Aboriginal people have a poor health status and a high burden of disease. The current system is failing and requires a transformation of the relationship between Canada and its Aboriginal people to find solutions together. The Aboriginal people must be at the First Ministers discussions on the Health Accord as these solutions involve all levels of government.

3. The recognition of health care as a public good for which no financial barriers must be erected. We affirm the need for a system of public health care which is organized on the basis of public administration, public insurance and the delivery of services on a public, not-for-profit basis.

4. Opposition to any commercialization and privatization of health care. Therefore the federal government must negotiate a general exclusion of health services and health insurance from all trade agreements.

5. The need for the federal government to fully assume its responsibilities in respect to health, particularly by securing the adequate and predictable federal health transfers and enforcement of the Canada Health Act.

*(continued on page 9)*

## SECURE THE FUTURE OF MEDICARE (continued)

6. The reaffirmation of the original vision of a truly comprehensive public health care system for Canadians providing a continuum of services. The next steps are the expansion of the public system to include a universal Pharmacare plan, a system of home and community care, long-term care, and a strategy for mental health.

7. The need to move towards a community-based, multi-disciplinary team approach to the management, organization and delivery of services, especially in primary care. Levels of services must be sufficient so that the burden of care does not fall on families, mainly women.

8. An accountable health care system through democratic participation and transparent governance at all levels.

9. The recognition that health care workers are critical to the effective operation of the health care system and that decent wages and working conditions are essential to high quality care.

We come together to commit to ensuring that governments throughout Canada renew their commitment to protect and expand Canada's public health care system to meet the present and future needs of all people living in Canada, based on the principles (public administration, universality, comprehensiveness, accessibility and portability) and conditions (no extra billing or user fees, or queue-jumping) of the Canada Health Act. Regardless of where we live, it is now imperative to reaffirm the social values we all share. These values must guide our collective choices for future of health care. What stands between Medicare and its destruction are the peoples of Canada. Future generations are depending on our vigilance.♦

# 25 IN 5'S EVALUATION OF ONTARIO PROGRESS ON POVERTY REDUCTION: GOOD EFFORT, BUT INCOMPLETE

*Excerpts from the Third Annual Progress Report on Poverty Reduction in Ontario*

Ontario has officially passed the halfway point to its promised target date of reducing child poverty by 25 per cent by December 2013.

Much has happened since December 4, 2008, the date the Ontario government announced its first five-year poverty reduction commitment. But, especially in light of ongoing economic

**The Gap Keeps Growing**

Ontario's income gap worsened during the best of economic times in the early- and mid-2000s and the trend shows no sign of abating. Historically, income inequality grew during recessions as middle-income workers lost jobs, but the gap narrowed once the economy recovered and jobs were aplenty. But that historical trend has changed. A growing body of research indicates income inequality is getting worse because of a new trend: the richest 10%, especially the top 1%, have become even better off, while those in the middle work longer and harder just to stay afloat – and the growing ranks of those at the bottom struggle harder to rise up the income ladder. The Conference Board of Canada recently indicated income inequality is growing at a faster pace in Canada than it is in the U.S. Action is urgently needed….

Cutting the taxes of those at the top has not led to the kind of growth that provides enough support for the rest of us. The gap keeps growing – not only in income, but also in access to jobs, education, services, and opportunity. It's a trend that Ontario can no longer afford to ignore, particularly in the current slow economic growth reality. The poverty reduction promise will grow cold without significant action in the upcoming provincial budget.

**The Growing Consensus on Government Revenue**

The growing chorus of Ontarians and Canadians calling for new tax measures to secure government revenues has recently been joined by some wealthy and powerful voices – giving governments all the more reason to do the right thing.

TD Bank CEO Ed Clark has been quoted as saying "almost every person at a recent meeting of the Canadian Council of Chief Executives said 'raise my taxes'" in order to slay the recession-induced deficit.

This October, the Conference Board of Canada's Glen Hodgson wrote: "Canadian governments still need to generate enough revenue to sustain key public services, re-balance the budget and manage public debt..."

*(continued on page 10)*

# 25 IN 5'S EVALUATION OF ONTARIO PROGRESS (continued)

**Policy + Action = Results**

The province's early actions are already bearing fruit, though not enough. When Ontario's poverty reduction strategy was announced, the global recession was in full swing. Anti-poverty groups urged the provincial government to take bold steps to protect people from the economic downturn. They urged government to increase the Ontario Child Benefit, boost the minimum wage, and match federal stimulus spending. They also called on the province to raise incomes for adults living in poverty.

The McGuinty government followed through on the first three steps. It also introduced full day junior and senior kindergarten. But, crucially, it did not do anything substantial to deal with income security for adults.

The results: Child poverty dropped. It is a little off pace of the government's target for a 25% reduction in five years. But it is a move in the right direction.

By contrast, poverty rates for working age adults in Ontario continued to climb. But even there, the story is more nuanced. Unemployment hit men harder than women during the recession. As a result, poverty among single men climbed steadily. Poverty rates for single women actually fell.

This suggests that those who were able to keep or find work benefitted from the protection of a higher minimum wage – since more women than men work for minimum wage. Those who lost jobs – particularly men – suffered from Ontario's punishing social assistance system.

**Lessons Learned**

The first lesson to be learned is that a government commitment matched by good policy can make a big difference in people's lives. The second lesson is that social and economic problems only grow when governments ignore them – wishing them away yields no fruitful results.

The story in Ontario during the worst of Canada's recession is telling on this front:

In Ontario, child poverty actually fell between 2008 and 2009, inching down from 15.2% to 14.6% using the province's own Low Income Measure. This 4.0% decrease means that 19,000 Ontario children and their families were moved out of poverty, despite very tough times. It's nowhere near the 25% target goal, but it's a stark contrast to other provinces that were also hit hard by the recession.

In Alberta, for example, child poverty soared by 25 per cent in the same period. What's the difference? Ontario took concrete action to reduce child poverty. Provinces like Alberta didn't.

**The Need to Do More**

But as we begin to see the rewards from investing in a poverty reduction plan aimed at children, the ramifications of ignoring adult poverty come into clearer view.

The poverty rate for all Ontarians aged 18-64 years – whether in families or single – was 13.4% in 2009. This means that 102,000 more Ontarians in this age bracket lived in poverty than in 2008 – almost a 10% increase over one year. The number of single people living on low income decreased slightly from 25.1% in 2008 and 24.6% in 2009. But 410,000 single people living in poverty – 198,000 men and 212,000 women – is still unacceptably high.

And we know that poverty discriminates. People in particular groups – like people from racialized communities, Aboriginal people, women, single mothers, people with disabilities, newcomers, and people living in specific geographic areas – are at greater risk, for structural and systemic reasons that must be addressed. Without additional, targeted action to deal with the disproportionate impact of poverty on people in these groups, the growing gap between the rich and the rest of us will continue to leave certain groups of people behind….

**The Cost of Poverty: We Have a Choice**

There is a growing body of research itemizing the cost of ignoring poverty. Ontario residents pay an estimated $38 billion a year – the price of allowing poverty to remain entrenched in our communities rather than nip it in the bud. There are long-term social and health costs associated with ignoring poverty as well.

The National Council of Welfare reports that about 20% of health care spending in Canada results from socio-economic issues, including income related disparities. "Canadians are paying the most in the least productive areas," says the NCW in The Dollars and Sense of Solving Poverty, "trying to fix costly problems linked to inequality, insecurity and poverty that are preventable."

Canada's Chief Public Health Officer reports that "the effect of social and economic status and/or differential access to health care, education, employment and housing can contribute to inequalities in health outcomes at every stage of life, including for youth and young adults."

And Richard Wilkinson and Kate Pickett have demonstrated in their international research that income inequality results in greater

*(continued on page 11)*

## 25 IN 5'S EVALUATION OF ONTARIO PROGRESS (continued)

social unrest, less trust in each other and in public institutions, higher levels of crime, greater incidence of depression and anxiety, and deteriorating health conditions.

Should Budget 2012 focus on protecting health and education spending at the expense of spending in other areas, the societal and financial implications could be considerable. Additional costs in health care and other areas – costs that arise directly from ignoring poverty and income inequality – are significant.

It's a steep price to pay for a problem with ready solutions at hand. Poverty reduction must not be ignored…. The conditions exist for moving forward together, by acknowledging and acting in areas of common ground. Let's get it done.♦

## MRG MEMBERSHIP APPLICATION

I would like to ___become a member ___renew my support for the work of the Medical Reform Group

### Membership Fees

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

Please specify membership category:

_____

Please specify areas of interest and expertise:

_____

_____

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

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

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

You may pay your membership fees and supporting contributions through our monthly payment option by completing the following authorization and **enclosing a blank 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 _____ day of each month, beginning _____, 20___.
Please credit the payments to the ALTERNA Savings and Credit Union account (No. 1148590) of the Medical Reform Group.
I understand that these electronic payments will continue until I give notice in writing to the Payee to stop doing so; that I must notify the Payee in writing of any changes to the information in the authorization; and that I must notify the Payee within 90 days of any error in the electronic payment.

Account holder's name (Please Print) _____ Account holder's signature _____ Date _____

# DOCTORS CALL FOR MORE EQUITABLE APPROACH TO ECONOMIC HEALTH

As the Occupy movement comes to Canada, the Medical Reform Group called for increased taxes on high income earning individuals and on corporations, including doctors.

"Many of us are privileged to make a lot of money," said MRG spokesperson Dr. Ahmed Bayoumi. "Yet we also understand how important income and social status is to health. Addressing economic disparities is essential to improving the health of Canadians and, more generally, addressing social disparities. An important and expedient way to address these inequities is to ask high income earners to pay more taxes"

"The last three decades have seen a disproportionate concentration of wealth among top income earners," noted another MRG spokersperson, Dr. Michaela Beder. She noted that the top 1 per cent of income earners earned one-third of all income gains before the recession struck in 2008. "Unequal societies are bad for population health," she added, "but they are also fundamentally unfair. There is no reason that a rich country like Canada should have the poverty levels that we do."

"The Occupy Wall Street movement has been educational and inspirational," noted Bayoumi. "Our income distribution might be more equal than it is in the U.S., but the trends are moving in the wrong direction." Bayoumi also criticized those advocating for lower corporate tax rates. "Corporations are also part of the social contract in a market economy," he noted." They also need to pay their share." He further noted that many doctors are now incorporated and pay lower taxes as a result.

Beder noted that even relatively moderate tax increases could fund such important health and social programs as a national pharmacare program, universal day care, or an increase in social assistance and employment insurance rates. "We stand with those occupying financial centres to demand that governments adopt fiscal and social policies in line with fundamental Canadian values," she stated. "It's about social justice." ♦

*Released by the Medical Reform Group*
*October 14, 2011*

**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]***