Medical Reform

Newsletter of the Medical Reform Group

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A FOND REMEMBRANCE OF CLYDE

All of Canada, and population-health as well as child development experts globally, were stunned by the sudden death in early February of Prof. Clyde Hertzman of UBC. While working with UK collaborators in London, Clyde went to sleep at a friend's house and simply never woke up. He was only 59 years old. A full tribute to Clyde in the Globe and Mail can be found at: http://www.theglobeandmail.com/news/british-columbia/clyde-hertzman-59-showed-how-environment-trumps-genetics-in-a-childs-development/article9016265/

Clyde Hertzman – Brilliant, Caring, Effervescent

I first met Clyde, as far as I can recall, in the early 1980s at a social event in Hamilton Ontario, for the dedicated environmental and occupational health research community then thriving at McMaster University -- or perhaps it was at a meeting of the still-vigorous Medical Reform Group of Ontario, a socialist physicians' organization that Clyde belonged to from its start-up. [Or was it at the Tire-Biters band party at Michael Hayes and Lillian Bayne's place??] My memory for detail is not what it once was… but I do remember being struck by Clyde's energy and articulateness, his passionate commitment to social justice… and his infectious warmth. Those memories of him are no different for the last time we interacted, in Scotland just a few years ago. We had invited him to Edinburgh to tell Scots about early child development and the EDI work that HELP has been doing in BC. This he did with his typically consummate skill and passion, so much so that even the normally reserved and ungenerous – did I say "dour"? -- Scots audience practically gave him a standing ovation (unheard of in Scotland.)

Inspirational speaking was only one of Clyde's many talents. An extraordinarily keen intellect, Clyde's thinking was never wedded to its past understanding of complex phenomena – he was ever thirsty for new facts or theories -- especially related to the social determinants of health, as they play out over the life-course. Clyde contributed more to our understanding, I believe, of life-course determinants of health than almost any other scientist of the last few decades.

Another indelible memory of Clyde was in 1987 when Michael Marmot (now Sir Michael) was first invited by Fraser Mustard to come to a Canadian Institutes for Advanced Research Population Health Program, to present his Whitehall Study findings about the "social gradient in health". Clyde and I were among

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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, Gordon Guyatt and Janet Maher

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

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

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

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

EDITORIAL NOTES

Janet Maher

The new Ontario Liberal leader, Kathleen Wynne, elected at the end of January, has committed to collaboration and consultation and may be able to make minority government work and avoid an early election. Our message of congratulations to her indicated some areas where we thought she could show leadership which had been largely neglected by her predecessor. Early indications are that she is finding common ground especially with the NDP. However, as can be seen with our letter to the Minister of Health and Long term Care, the issue of user fees for drugs and home care targeted to the elderly, sick and vulnerable still seems to be on the table.

Another area where we have been urging provincial authorities to 'do the right thing' and begin seriously to address the social determinants of health has been on the poverty file. At press time, a date for the provincial budget has not yet been released, but it appears that the recommendations—especially those with financial implications—of the Social Assistance Review Commission, released last year seem to be getting pretty limited attention at the provincial cabinet table.

Nonetheless, a recent Op-Ed by Gary Bloch in the Globe and Mail has, we hear, popped up in many physicians' offices across the country. Bloch's message—press low income patients to file their taxes, to get at least the tax-related benefits they qualify for. See his article at www.theglobeandmail.com/commentary/as-a-doctor-heres-why-im-prescribing-tax-returns-seriously/article9981613.

At the federal level, the 2013budget is notably silent on health care. Consistent with Conservative commitments to their base, they believe they have met the spirit if not the letter of the so-called Accord which expires next year, with the health transfer tied to economic growth, with a 3 per cent floor—and not a word on national standards. What continues to worry us as well are the effects of multi-year public service curs and the shift to a risk management approach on issues of health protection which will continue to reduce inspection and infrastructure, even as we see increased evidence of corporate Canada's inability to police itself adequately in areas of food, water and environmental quality.

The combined work of the Canadian Doctors for Refugee Care and the Canadian Association of Refugee Lawyers resulted in late February in the launch of a constitutional challenge of the Interim Federal Health Program (IFHP) 'reforms'. Several provinces, embarrassed by the inconsistencies of the so-called reform--in which refugee claimants awaiting finalization of their cases, work and pay through their taxes for health care for others but do not qualify for care for themselves—have taken to paying for care previously covered under the IFHP and agreeing to recover those costs from the federal government. Also in February, Toronto City Council agreed to a Community Services staff recommendation to review all municipal agencies to improve access to city services for undocumented people in Toronto. ♦

A FOND REMEMBRANCE OF CLYDE (continued)

the few "card-carrying epidemiologists" in the room. Although still pretty wet behind the ears compared to our esteemed guest, we were naturally sceptical of such strong inverse relationships between a variable we had never learned about in medical school (pay grade in the UK civil service) and every health outcome you can imagine. In fact, we conferred in private at the coffee break and agreed to challenge the august British professor's data. Summoning our collective courage we asked him "We see the relationships, Michael, but we are sceptical – (now breathing deeply) Are these data properly age-standardized?" Michael's polite but slightly disdainful response was "Well, of course – standardization is methodologically less satisfactory in this situation with wide age-ranges and long-follow-up, so we have used multivariate modelling to capture the usual exponential relationships of mortality with age." Clyde and I immediate retreated, in some disarray, clearly out of our depth, shot like fish in a barrel by a very fine archer indeed.

By the end of the 1980s, the intellectually ever-restless Clyde had moved on – having already been named principal investigator of the highest-quality environmental epidemiological study then ever published, in a 1986 structured review – he was by this time looking beyond the likes of the Ottawa Street Dump in Hamilton (where he did that fine study), and sought to work at a higher geographical level… say… all of Eastern Europe! Clyde proceeded to conduct landmark studies of the old Soviet block societies' then burgeoning health problems --it was the early 90s and the Soviet regime had just collapsed from within. Those of us in the CIAR "Pop Health Program" received regular live updates from him at meetings. It was fascinating to hear Clyde think through and test the several hypotheses then current, as to why these countries' health status was going to hell in a hand-basket, fast. What Clyde probably knew from the very start of the project, but was careful not to say until he completed his investigations, was unsurprising given his deep grasp of environmental health: that such sudden and catastrophic declines in health, across over a dozen countries, were unlikely to be due to longstanding Eastern Block industrial pollution alone, dreadful though he soon found it to be, first-hand. There had to be something else going on, something that worked much faster to destroy a population's health on a massive scale. By the end of the project, he convinced himself – always a tough job in Clyde's case – and then all of us, that the culprit was society-wide "psychosocial stressor exposure," occasioned by the economic chaos, collective mistrust of others, and widespread anti-social behaviour. Post-Soviet client-state societies experienced health declines when the centrally planned economy and police-states of the old Eastern Block collapsed. We were stunned. Then, over the following decade of CIAR Pop Health meetings, Fraser Mustard, Bob Evans (the first Program Director), and then Clyde (as his successor), brought speaker after speaker to explain to us – from vantage points as diverse as primatology and epigenetics – just how this sort of effect is mediated in the mind-body continuum. And now all this is conventional wisdom – but not then.

So, Clyde and I learned together, more or less over the same period, like the proverbial Bobbsey twins. We were among the younger and more medicalized of the Pop Health Program membership, and in some ways therefore had the most to learn. But by the time Bob Evans, Clyde and I wrote our rather prescient Chapter 3 in "Why Are Some People Healthy and Others Not?" – on the lanai of my wife's and my sabbatical house in Honolulu in 1990 -- we were pretty much singing from one synthesized, trans-disciplinary hymnbook. Most of us from that Pop Health Program still are.

Clyde's own intellectual journey, however, did not stop there. He fell in love with early child development, still thought by most of us to hold the essential key, to levelling life's uneven playing field for different social classes. And, typical of Clyde, he didn't trifle with half-measures. He threw himself full-time, for the rest of his life, into showing that British Columbia's diverse communities, from the Nass River to Kamloops to Tsawassen, could and did benefit from regularly measuring their children's development, in a way that could be easily understood by everyone. That legacy has of course led to the continuing "viral" uptake of the EDI worldwide, something Clyde happily did live to see.

In the end, there was much he still wanted to do – so it is up to the rest of us now, to try and carry on that work, as best we can. Here's a toast to you, my brother – you are and will continue to be (for a very long time) much missed. ♦

John Frank, Edinburgh, March 15, 2013

RITIKA GOEL: HEALTH ADVOCACY FOR THE 21ST CENTURY

Janet Maher sat down with recent family medicine graduate Ritika Goel to ask about herself and her decision to become a family doctor.

Can you tell me a little about yourself and how you came to be a family doctor?

I've been working as a family physician in Toronto for just under two years now. I was drawn to family medicine as a specialty of choice both because of the wide breadth of knowledge it requires and also the significant relationships one can build with patients as a primary care provider. My interest in inner city health and public health also drew me to family medicine as it puts you 'on the frontlines' and often is where many interventions into the social determinants of health are carried out. In my first year after completing residency at St. Michael's Hospital in Toronto, I locumed in various inner city settings in Toronto, and then left the city to pursue a Master of Public Health which gave me the opportunity to further expore my interest in policy and systems. I'm working now with an organization called the Inner City Health Associates which is a group of approximately 60 family doctors and psychiatrists working with people experiencing or at-risk of homelessness in Toronto. We work in about 40 community agencies including shelters and drop-in centres. Aside from the clinical work, which is both highly challenging and rewarding, I'm serving as the Population Health Lead. This position allows me to take a high-level approach to our work at ICHA and the broader care of individuals experiencing or at-risk of homelessness. It has allowed me to work on quality improvement inititatives and push the limits of how we can best improve the health and wellbeing of our patients. While I greatly enjoy both the clinical work and the population health work, I do still find myself facing systemic barriers that both are unable to address which leave me turning to activism. This is what drives my continued push to advocate for an expanded and strengthened Medicare in Canada as well as access to health and services for all, regardless of immigration status.

I know you have been active as a resident and a new graduate on a number of advocacy files, including migrant health and the anti-poverty file. What has brought you to that?

As a South Asian immigrant myself, I've always wanted to connect with migrants, in the hopes that they can feel that their healthcare provider can understand their struggles. I was used to seeing patients' eyes light up when I spoke in Hindi if they were South Asian, or talked about my childhood in East Africa if they were from that region. In my experience, for migrants who often feel so far from familiar surroundings, finding someone else who knows their homeland can be very powerful and comforting. I particularly enjoy working with migrant women of colour who I feel a strong kinship with.

While I pursued working with migrants previously as a clinical interest alone, about four years ago, I learned that Canada's healthcare system is in fact not universal and excludes an estimated 2-500,000 people due to their immigration status. I heard terrible stories of a woman who waited until she was unconscious before she was taken into the emergency room, another of a man who succumbed to esophageal cancer after being denied treatment, a family that got a bill of around $40,000 for their child's ICU admission. This was so shocking to me when I learned it that I became immersed in the issue along with several friends and like-minded individuals. We continue to work on these issues as an organization called "Health for All," and have most recently been involved in mobilizing around the refugee health cuts, just one in a slew of policy changes that target migrants in this country as of late.

My anti-poverty work has been driven by a profound sense of injustice for those living in poverty who are discriminated against by our health and social service systems when clearly the evidence all proves that income is the largest determinant of health. A lot of my recent work has been focused on medical education with students, residents and other practitioners to ensure they are doing what is within their power both as a provider to secure more income for patients and also as an advocate, both for patients but also as people who believe in social justice. I've never quite understood why our society spends so much time demonizing people who have experienced significant hardships, instead of calling for more just systems that would prevent those hardships.

What skills do you bring to this activity (advocacy) as a result of your medical education and being a physician?

In theory, medicine teaches us to think about what is best for the

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health of our patients. If we were to take this to its logical extension, it would mean not just providing high quality patient care but also looking at how we can advocate for systems change such as a living wage which would likely impact the health of our patients much more than anything we would provide medically. Unfortunately, despite the laudable efforts of a minority, going through the actual process of medical education largely institutionalizes biases towards many groups in our society. On the not-so-politically-correct wards, we see not what our supervisors say but what they and their colleagues do. Attitudes that social assistance recipients are abusing the system run rampant and poor treatment of people of colour, people with mental illness, and people with addictions is commonplace. The more experiences trainees have where patients are humanized rather than dehumanized earlier on the better. This requires a large cultural shift but through the work of various patient advocacy groups we are hopefully moving in this direction.

The truth is that by far the most significant thing I gained through my medical education that likely contributed to my activism is physician privilege. This does not mean 'the great honour of being a physician' but rather the unstated benefits I receive in this society as a result of my social status as a physician. Aside from being a physician, I am a South Asian immigrant woman of colour which is not a very privileged position in this society and were it not for my physician status, I likely would not be given as much credibility or public space to express my views as I currently am. (This is not to ignore the privilege I also have as a heterosexual, cis-gendered, able-bodied person). I have so far attempted to use the privilege afforded to me in this social position to further the cause of social justice, but I am aware that the credibility afforded to me originates from a health and social system that is unnecessarily hierarchical and oppressive towards other professions. I think if we are afforded privilege in this society, it is definitely our responsibility to channel it for the greater good, but also very important to challenge and not reinforce it.

Can you explain the recent refugee health cuts and how they fit in to the broader context of immigration policy changes in Canada?

In April 2012, the Minister of Citizenship and Immigration, Jason Kenney, announced cuts to the Interim Federal Health (IFH) Program presenting it as taking away 'gold-plated healthcare' from people who were abusing our 'fair and generous immigration system'. Both of these statements are of course very misleading. Previously, IFH covered both refugees who arrived in Canada with protected status (government-assisted refugees and privately-sponsored refugees) as well as those who came to Canada and made a claim (refugee claimants). All these groups could get access to physicians and hospitals as all Canadian citizens have through Medicare, as well as access to medications, and some minimal dental and vision benefits, similar to what all citizens have on social assistance. The understanding there is ofcourse that similarly to those on social assistance, newly arrived refugees have financial barriers (as well as social, language and more) that would make it hard for them to obtain private insurance to cover those benefits. The cuts had three main impacts: First, all refugee claimants and privately-sponsored refugees lost access to the coverage for drugs, dental and vision leaving some diabetics without coverage for insulin. Secondly, newly arrived claimants had to wait up to six weeks to meet with their immigration officer before getting their IFH leading to awful situations with pregnant women delivering babies with no coverage. Finally, Kenney annouced a list of 'safe countries' (35 so far) from which refugee claimants get effectively no healthcare coverage. This applies to anyone making a claim from these countries after December 15th, 2012 and includes most notably Hungary and Mexico, are two main sources of refugee claimants in the past few years. These cuts have of course led to terrible situations and the health sector as well as migrants themselves (most notably the Roma community in Toronto) have fought the cuts loud and proud. Our organization most recently led a campaign to get the province of Ontario to fill the gap in healthcare coverage as the provinces of Manitoba and Quebec have said they would. Thus far, we have not seen much movement on either front, federally or provincially, and sadly, it's likely only a matter of time before a life is lost.

In terms of the context, however, this is not entirely surprising. Along with the cuts to IFH, Kenney has also just passed Bill C-31 which drastically reduces the processing times for refugee claimants (from a historical timeline of 1-2 years to 30-60 days). This will make it exceedingly difficult for lawyers to acquire the required documentation to make the appropriate case for the claimants and likely many will be denied and become undocumented and un-

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RITIKA GOEL: HEALTH ADVOCACY (continued)

insured. 2012 saw the lowest rates of refugees accepted in Canada in a long time while we continue to see rates of temporary foreign workers, who do not have a path to legal status in the country, rise. They have also legally permitted temporary foreign workers to be paid less than citizens doing the same job and do not allow them to access EI benefits even though they pay into them. A few years ago, the government also put an indefinite ban on sponsorship of parents and grandparents, instead instituting a 'super visa' that requires them to purchase private health insurance before coming to Canada. Overall, Kenney and the government have engaged in a dangerous game of us vs. them rhetoric pitting migrants againt 'ordinary Canadians' and even immigrants vs. refugees. So while the refugee health cuts are shocking and to be loudly and publicly denounced, it's also important to remember that there were previously large numbers of uninsured and people with precarious status as well as other regressive immigration policies that also demand our attention and outrage.

A couple of weeks ago, a research report was released by Stephen Hwang on access to doctors' offices, which suggested that even in the situation of universal access there may be some discrimination against low status patients? What is your sense of this, and what can physician advocates do to improve the situation?

This is not surprising to me in the least. These biases are strongly built into our larger society and also our medical systems. There are many things that could be done at a systems level to ameliorate these issues – compensating physicians based on complexity of care and patient's income status, stronger accountability mechanisms that prevent physicians from interviewing and declining patients with low incomes and more. Part of the issue is that medicine is a career that attracts people of upper middle income status themselves who may not have had exposure to marginalized people and therefore engage in the stereotyping of otherwise marginalized people. This can be ameliorated by decreasing medical school tuitions or having spaces dedicated for people of colour, people from low-income families, aboriginal people etc. The Latin American School of Medicine in Cuba provides scholarships to young people in countries around the world that live in poor communities and wish to study medicine – the only caveat is that they must return to serve their community. Similarly, if Canada prioritized making medical education more accessible, we would see more physicians who themselves have a diverse background and more nuanced understanding of such issues making them more likely to work in these communities and also be more empathic physicians.

What do you see as the 2 or 3 main policy issues for you as a physician advocate? If this is where you are likely to put your energy in the next five years, what will your work look like?

On the migrant justice front, continuing broader education related to the issues of the uninsured and thinking of how we can provide health for all is crucial. With the current government in place, more and more regressive immigration policy changes are announced on a regular basis so much of the organizing ends up being reactive to protect what already existed. As a ray of hope, recently the City of Toronto passed an "Access Without Fear" policy which makes Toronto the first North American 'Sanctuary City'. This means that the city recognizes the right of an individual to access services regardless of the immigration status. While this is tremendously positive and hopeful, I think a lot of work will have to be done to hold the City accountable and ensure that this policy is being instituted. It also means thinking creatively as currently so much of our access is tied to status (eg. OHIP cards).

In terms of health policy, I see universal pharmacare as the issue of the day. Given that most high-income countries provide medications as part of their publicly-funded healthcare systems and Canada does not, it seems the most logical next step for the expansion of the Canada Health Act. I think this is winnable given all the recent support for this from various academics, institutions and of course organizations made up of people who suffer for lack of such a policy. Given the strong evidence that bringing medicines into our single payer umbrella would lead to huge cost savings as well as more thorough coverage, the arguments are all there.

What do you think physicians and others in the health professions can/should do in their day-to-day work and on the broader scale?

I think all health providers are in a unique position in society as they, by virtue of their jobs, come into contact with people from all different walks of life. Given the social determinants of health tell us that people of colour, people with lower incomes, people with poor housing are all more likely to be unwell, health providers come into contact with them. As such, even if our own

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RITKITA GOEL: HEALTH ADVOCACY (continued)

experiences do not expose us to struggles, our work does, and therefore leaves us with a responsibility to work with marginalized communities to advocate for a more just society. While it is important for health providers to not speak on behalf of marginalized people, it is important that they speak nonetheless to stand in solidarity with those who they serve. This means completing forms that allow them to access various income supports that they are entitled to but also joining them in the streets to demand subsidized housing and childcare services.

We can also, as physicians especially, work to deconstruct our own privilege in healthcare spaces. This can mean not wearing a white coat, asking the other health providers and patients to use your first name instead of 'doctor' and by constantly prioritizing a patient's preference and autonomy in decision-making.♦

MRG URGES ONTARIO TO 'FILL THE GAP' LEFT BY FEDERAL IFHB CUTS

Steering Committee Member Ahmed Bayoumi penned this letter to the Minister of Health and Long Term Care, Deb Matthews on January 28th, 2013.

In July 2012, the Federal Government implemented cuts to the Interim Federal Health Benefit. Those cuts include the elimination of essentially all health coverage for refugee claimants from countries the Federal Government deems "safe", regardless of the individual circumstances that compel the individual or family to seek refuge in Canada. The cuts also deny all refugee claimants and privately-sponsored refugees access to essential medicines and other services. These cuts are impacting the health status of those seeking refuge in Canada and represent a serious threat to the health and safety of all Ontarians and Canadians.

The provincial governments of Manitoba and Quebec have opposed these cuts and have elected to fill the gap left behind by the bad public policy initiated by the Government of Canada. We believe that the Ontario government should take action, and to bridge health care for individuals affected by this health crisis and then move to advocate with the Government of Canada, sparing some of the most needy at their time of greatest vulnerability.

If Ontario chooses to do nothing, our provincial government sends a clear message to immigrant communities that Ontario does not care about their health and wellbeing. As Ontarians, we are also concerned that by doing nothing in this situation, our government would also be making a decision to accept the downloading of costs from the federal government onto our province.

As health care providers, we are fully aware how this further strains our emergency departments, hospitals and Emergency Medical Services with unnecessary delays in care resulting in emergency complications. Ontario, too, could follow the lead of Manitoba and Quebec in providing health coverage that was once available and it could collaborate with them to press the Federal Government to reverse the cuts.

We believe this is a positive message that Ontario supports the rights of all those seeking refuge to live with health and dignity. It would also be in line with evidence that suggests treating health through primary care in the community is less expensive than treating the resultant emergencies in hospitals. We strongly encourage you to make the socially responsible decision and fully fund health care for all those seeking refuge in Ontario, and as previous generations of newcomers will attest, is repaid over and over in building our provincial and national economies once the newcomers get settled.♦

MIDWIFERY FOUNDER AWARDED ORDER OF CANADA

Long time member Murray Enkin was recognized in the Governor General's New Year's Honours List, as noted in in this item published on the McMaster University website January 2, 2013. Another member, Dr. Debby Copes offers a very personal memory of her first contact with Dr. Enkin.

Murray Enkin, a professor emeritus of the Michael G. DeGroote School of Medicine, is being made a member of the Order of Canada for "his contributions to maternal care and the development of midwifery as a recognized profession in Canada."

The announcement of the awarding of Canada's highest civilian honour was made earlier this week by Governor General David Johnston.

"From McMaster Dr. Enkin introduced welcome patient-centred changes for mothers and their babies which have improved their care for more than 40 years, and he led our University to establish Canada's first midwifery program," said Dr. John Kelton, dean and vice-president, Faculty of Health Sciences at McMaster University.

"We're glad to see his innovation and excellence recognized with the Order of Canada."

Enkin, who graduated from the University of Toronto medical school in 1947, joined the medical school after its founding, and became renowned for his focus on the patient perspective in medical practice, especially in family-centred maternity.

Congratulated on his Order of Canada this week, Enkin said a lot of the credit goes to McMaster. He said he chose to practice in Hamilton precisely because it was close to a big city but it didn't have a medical school "because I was tired of academia. Then the medical school started, and it was so innovative and exciting, I had to jump right in."

The professor emeritus of the Department of Obstetrics and Gynecology and Clinical Epidemiology & Biostatistics now lives in Victoria, B.C. Among his other awards are an honorary degree from McMaster and induction in the Faculty of Health Sciences' Community of Distinction.

His medal will be presented in a ceremony at Rideau Hall in Ottawa at a later date. ♦

In 1973, early in the year I began medical school (but before I knew that I would) I became pregnant with a Dalkon Shield in place. The OBGYN in Toronto who had inserted it told me he would perform the abortion I requested, but I was second in line to another patient who was later in her pregnancy than I was.

I called this doctor's office every few days, as instructed, hoping to be given a date for my abortion. A couple of weeks went by, and I began to panic as I learned that the woman in line ahead of me had not had her procedure yet either.

An acquaintance of mine told me about her OBGYN in Hamilton, a Dr. Murray Enkin, who was a wonderful doctor and supportive of abortion rights. She urged me to call his office and ask for an appointment.

I explained to the woman who answered this doctor's phone what my problem was and how I had gotten his number. She asked me to hold, and a short time later the doctor himself was on the line. He asked me both about the pregnancy and about my personal situation. He told me (with much apology) that he could not undertake to do abortions for women who were not already his patients, because if he did then he would be busy day and night doing abortions, such was the need. But he exhorted me that I had a complete right to have one, and that my doctor in Toronto was treating me unconscionably by not giving me a firm date for the procedure. He advised me to sit in my doctor's office and refuse to leave until I had a commitment.

I felt quite energized and even empowered by this doctor, a total stranger with no obligation to me, who took my call in the middle of a working day to urge me to demand my rights!

Upon following Dr. Enkin's advice, my doctor responded to my assertiveness by handing me a piece of paper containing the name of an abortion clinic in Buffalo, New York. I called and made an appointment for a few days' later.

This was an acceptable personal solution, given that I could raise the $200 required, and I had friends who could drive me there and back. I could have taken the bus if necessary. I realized how I privileged I was to be able to buy my way out.

The continued efforts of many Canadians, Dr. Enkin prominent among them, has vastly expanded access to abortion services in much of Canada, and women in Toronto no longer need a passport and funds to get a safe and legal abortion. But we must remember that there are still significant barriers for woman in other parts of the country, especially women in rural and remote areas and those in the Maritime provinces. I hope to continue the fight for their rights too, paying forward the assist that I had from Dr. Enkin 40 years ago. ♦

MRG CONGRATULATES KATHLEEN WYNNE ON LEADERSHIP WIN

Steering Committee Member Ritika Goel set out our priorities for the Ontario government in 2013 in her letter of January 28, 2013.

I am writing to congratulate you on your recent election as Leader of the Liberal Party of Ontario, and premier-elect of Ontario, on behalf of the Medical Reform Group (MRG), a voluntary association of physicians and medical students who work in coalition with many community groups to address the health and medical implications of their advocacy. As you know, the MRG has been active for over 30 years, promoting social justice and health, and advocating for high-quality publicly-funded health care for all Ontarians.

We look forward to working with you and your new cabinet in the coming months on four important issues, which, if well-resolved will make the Ontario economy more competitive and will contribute substantially to easing the suffering of some of the most vulnerable Ontarians:

• Social Assistance: As you indicated in your acceptance speech on January 26th, Review Commissioners Frances Lankin and Munir Shaikh devoted considerable energy to considering training and benefits options that would help those capable of being employed to move in that direction as expeditiously as possible—to the benefit both of individual recipients and the Ontario economy more generally.

The MRG has consulted and participated in consultations on this issue since the Thomson Committee produced the TRANSITIONS report with many similar recommendations in 1988. We are convinced that further study is not necessary, but political will is essential to ensure that the most vulnerable who are less likely to be employable in the short term have access to adequate social and health benefits.

• Refugee Health: Your colleague, the Hon. Deborah Matthews, recently met with a group of health care providers seeking action from the Ontario government, similar to that already committed by several other provincial jurisdictions including Manitoba and Quebec to provide care to those previously covered by the Interim Federal Health Benefit.

We agree with Minister Matthews and the other health ministers that this sort of provision is a responsibility of the federal government who authorizes immigration. However, we think it would be more humane for your government to provide the care, and collaborate with provincial ministers and premiers and the great majority of the Canadian public to pressure the federal government to reverse its downloading of this relatively small expense for governments, but which can mean the difference between life and death for some newcomers. Estimating that approximately sixty per cent of the Canadian refugee caseload comes to Ontario, and that the federal government expected to save up to $20 million a year with the download, this would amount to about $12 million in Ontario—approximately $1 for each resident of the province and could be delivered in the form of outpatient care rather than adding to the pressure on emergency rooms.

• Escalating Drug Costs: We were heartened in early January to hear of the plans of one of the Council of the Federation subcommittees to begin bulk purchase of 6 of the most common generic drugs on a pilot basis, which would result in a savings to the Ontario Drug Benefit Program approaching 50 million a year.

As we have advised successive premiers and health ministers in Ontario, the most effective way of slowing the spiraling increases in health care costs due to the cost of drugs would be a pan-Canadian strategy. We commend for your information the critically acclaimed research completed by Carleton University professor Marc André Gagnon last year. In concluding that Canada cannot afford not to have universal Pharmacare, his analysis shows that rational implementation of universal Pharmacare, with first-dollar coverage for all prescription drugs, would not only make access to medicines more equitable in Canada and improve health outcomes, but also generate savings for all Canadians of up to $10.7 billion in prescription drugs. (The Economic Case for Universal Pharmacare, page 5)

(continued on page 10)

MRG CONGRATULATES KATHLEEN WYNNE (continued)

Moreover, a 2012 study by Toronto health researchers (Booth et al.) concludes that universal drug coverage at age 65 reduced inequities in MI, stroke and mortality, with estimates of the number of events that could be prevented among younger populations.

• Improved access to home care: In the course of our work as primary and specialist health care providers, we are aware of the value good quality accessible home care can have, for individuals who are keen to stay in their own homes, and for health care systems more broadly when they can dedicate high cost hospital and clinic care primarily to those who can benefit most from it.

We are also aware that there are significant disparities in access to care from one health region to another. As in the other issues raised in our congratulatory message to you, the issue has been studied for far too long, without noticeable results, and so we call on you to facilitate the kind of political will that will see Ontario doing more to have the right amount of care at the right time and place.

Our group includes many recognized experts in health services and in individual medical specialities, and we look forward to working constructively with you over the rest of your term. ♦

NEW PREMIER MUST ENSURE ONTARIO PROVIDES HEALTHCARE FOR REFUGEES, SAY DOCTORS

In the wake of a provincial leadership race declaring Kathleen Wynne the new premier of Ontario, doctors continue to advocate for their patients who have suffered from cuts made to Canada's refugee health care system on June 30th, 2012. This past Wednesday, January 23rd, 2013, a group of health workers and students demonstrated outside the Ministry of Health and Long-Term Care and secured a meeting with Deb Matthews to deliver a petition with over 1000 signatures of frontline workers and community members calling on Ontario to "fill the gap". They highlighted the fact that both the provinces of Manitoba and Quebec have come forward making commitments to provide health care for those who have been affected, and called on Ontario to do the same.

"The federal government's actions have left some of the most vulnerable in our society without basic access to medical care. This is unacceptable." said Dr. Ahmed Bayoumi, an MRG spokesperson. "It is Ontario's responsibility to deal with the reality on the ground. These people need access to healthcare, just like anybody else."

The cuts to the refugee health program mean that all refugee claimants and most privately-sponsored refugees have lost coverage for essential medicines, basic vision care and emergency dental care. Moreover, the most recent iteration of the cuts leaves refugee claimants from so-called 'safe' countries who made their claims after December 15th with practically no health care coverage. A list of 27 'safe' countries was announced in December by Jason Kenney, Minister of Citizenship and Immigration, and more countries are expected to be added to this list. The list prominently featured Hungary, the current largest source of refugee claimants in Canada, where the Roma people are known to be persecuted as documented by human rights organizations.

"These cuts mean parents cannot take their children to the doctor when they are sick and don't have coverage for themselves in the event of a heart attack." said Dr. Gordon Guyatt, another MRG steering committee member. "We acknowledge the gesture made by Deb Matthews in agreeing to meet with healthcare workers to discuss this issue, but ask her now to work with the new premier, Kathleen Wynne to devise a solution to provide health care for this vulnerable group." ♦

Released by the Medical Reform Group January 31, 2013.

USER FEES FOR HOME CARE?

When Mt. Sinai Director of Geriatrics Dr. Samir Sinha released his report, Living Longer, Living Well which was intended to be the foundation of the province's new Seniors' Strategy, many hoped for a final resolution to issues that have increasingly compromised the ability of seniors to continue to 'age in place'. Minister of Health Deb Matthews denies hearing much criticism of her proposal to extend means-testing and formal user fees into home care and to broaden the categories subject to senior drug user fees. Ritika Goel wrote the Minister the following letter on behalf of the MRG on April 4th, 2013.

I am writing on behalf of the Medical Reform Group which is a signatory to the Open Letter from the Ontario Health Coalition, Care Watch and the Alliance for Seniors to emphasize a couple of the central points in their open letter.

Recently, you released the final recommendations of Ontario's Seniors' Strategy. Included in the strategy is a plan to have seniors pay user fees for home care services, based on their incomes. This comes on top of a recent proposal to expand income-based user fees for seniors' drugs. On the face of it these proposals might sound innocuous and perversely fair. If the wealthy can afford to pay, so the argument goes, then why not have them pay out-of-pocket and relieve pressure on the public system? Private clinics use the same argument to push for all-out hospital privatization. There are, however, good reasons to resist the incremental expansion of user fees, not the least of which is because they effectively target the frail and ill elderly at their time of greatest vulnerability, rather than spreading the costs across the whole population through fairer taxes.

Universal publicly-funded health care is understood as a fundamental value in Canada. The idea that judge and janitor would share the same hospital ward is a cornerstone to our health system and it ensures that we all share a common interest in insisting on quality health services for everyone. As that health system is changed -- as services are moved from hospitals to home and other community settings – the fundamental value of equity that underlies our public health care system must not be abandoned. Otherwise, reform is simply a cover for the piece-meal dismantling of public health care and increasing the vulnerability of those least able to care for themselves and their families.

We are very disappointed that your government has expanded the notion of means-testing for home care, and within less than a year, shifted from a plan where only the richest 5% of seniors would pay user fees for drugs, to consider one which would expand user fees and means testing to all seniors. Means-tested home care would simply add to the burden of costs for care for the people who need it most.

Publicly-funded health care is about taking care of each other. We pay through our taxes when we are of working age and healthy and we share the cost across society so that the burden for care is not shouldered by the sick, the elderly and the dying. This is a point of pride for most of us.

For the Medical Reform Group, this means that the principles of the Canada Health Act must not only be safeguarded for hospital and clinic care, but also be extended to cover home care and drugs as health care is reformed to allow more of us to 'age in place.' This strategy, we believe, would likely result in overall health care savings even without fees as our elders enjoy better health with fewer hospital and emergency visits.

The reality is that universal public coverage for senior's health care is increasingly eroding, and what was once a slippery slope is threatening to become an avalanche. This is two-tier health care. Moreover, it is a false economy to dress up as savings what are clearly costs for needed care downloaded to the frail and ill who already pay disproportionately because they are the population group that requires these services more. Ontario has a legislature with longstanding democratic practices including public hearings and appropriate opportunities for public input. This must be respected, especially under a minority government. Privatization of vital health services and abrogation of fundamental principles are a major policy decisions. We look forward to joining in a fulsome public debate before any further policy change is contemplated. ♦

CONSTITUTIONAL CHALLENGE ON INTERIM FEDERAL HEALTH PROGRAM CHANGES

On February 25th, 2013, Canadian Doctors for Refugee Care (CDRC) joined the Canadian Association of Refugee Lawyers (CARL), and three individual patients to ask the Federal Court to declare that federal government health cuts to refugee claimants unconstitutional and illegal. This update draws on the CARL website for background.

The Legal Challenge to Cuts to Refugee Healthcare. A legal challenge has been launched in the Federal Court of Canada, arguing that the federal government's cuts to refugee health care are unconstitutional, and in breach of Canada's obligations under international law.

The challenge argues that the cuts to refugee health care violate the fundamental human rights of refugees, as protected by the Canadian Charter of Rights and Freedoms, without any lawful justification.

The cuts threaten the rights to life and security of the person in section 7 of the Charter.

The Supreme Court of Canada has already made clear in the Chaoulli decision that denying medical care can increase the risk of medical complications and cause severe psychological stress that threaten the security of the person and can even lead to death, in violation of section 7. The government has not clarified its reasons for these cuts. Assuming that the goal of the cuts is to discourage fraudulent refugee claims, there is no evidence that these cuts will have that result. Accordingly, the government's decision to cut health care benefits is arbitrary and unjustified.

The cuts amount to cruel and unusual treatment, contrary to section 12 of the Charter.

These cuts reduce or deny basic and life-sustaining health coverage for refugee claimants, likely causing significant and unnecessary pain and suffering to refugee claimants. The changes to the refugee health care coverage are inconsistent with international practice; numerous European countries provide more comprehensive healthcare coverage to refugee claimants than Canada.

The cuts discriminate against refugees from certain countries, and discriminate against people based on their immigration status, contrary to section 15 of the Charter.

For the first time, the type of health care coverage provided to a refugee depends on their country of origin. The federal government's changes to refugee health care insurance deny medical assistance to people from certain countries, such as Mexico and Hungary, which have been designated as safe by the Minister, while providing care to refugees from other countries. The cuts to refugee health care also discriminate on the basis of immigration status by denying basic health care to individuals residing in Canada on the grounds that they are seeking refugee protection.

The cuts are inconsistent with Canada's international law obligations.

Under the Convention on the Rights of the Child and the Convention Relating the Status of Refugees, Canada is obliged to provide basic health care for refugees and children. The cuts do not comply with those obligations.

Canada has a long tradition of providing basic health coverage to refugees. The Interim Federal Health Care Program, a federal insurance program, has historically provided temporary health, vision and dental insurance to all refugee claimants and resettled refugees, up until the time they were either accepted as refugees and were eligible for provincial health care, or if not accepted, until they had exhausted their legal options to remain in Canada. Refugee claimants have received some type of interim federal health insurance coverage since 1957.

Cuts eliminate most federal healthcare benefits for refugees—even if they are children. On April 5, 2012 the federal government passed an Order-in-Council to make drastic cuts to the health benefits paid by the federal government to refugee claimants. These changes were made without advance notice or consultation with the provinces or health and immigration stakeholders. The cuts came into effect on June 30, 2012, including the following:

- Refugee claimants have coverage for medical services, but no longer have federal coverage for vision care, dental care or prescription medications—even life-sustaining ones such as insulin. This rule even applies temporarily to privately sponsored refugees—people who Canada recognizes as being in need of protection.

Examples:

A child refugee claimant with a heart condition awaiting his hearing develops a dental abscess. The infection can spread to his heart, yet he

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is unable to receive dental care while awaiting the outcome of his family's hearing.

A refugee claimant is diagnosed with cancer after he arrives in Canada but before his claim has been decided. He can see a doctor but has no insurance to cover the costs of his chemotherapy or medication.

- Refugees from countries that the Minister has designated as safe ("Designated Country of Origin" or "DCO"), such as Mexico and Hungary, as of Dec. 15, 2012 receive no medical care at all, unless their condition poses a public health risk or security concern for Canadians.

Example:

A woman who is five months pregnant flees her abusive partner in Mexico. As Mexico has been designated as a so-called "safe" country, this woman will not only have no access to any prenatal care, she will also not have health coverage for the delivery of her child, or postnatal care.

- Refugee claimants whose claims have been rejected can only obtain medical care where their condition poses a public health or security concern. Even where the person cannot be removed from Canada, due to a government-issued moratorium on removals to particularly dangerous countries like Afghanistan or Iraq, she or he has virtually no health coverage despite being able to work legally in Canada.

Example:

A refused refugee claimant from Afghanistan cannot be returned to Afghanistan, given that there has been a moratorium on all removals to Afghanistan since 1994. He is able to obtain a work permit so that he can support himself while his immigration status is in limbo. If he has a heart attack, as a refused refugee claimant, he is not entitled to health coverage for treatment or for necessary medications.

Cuts to refugee healthcare have significant impacts. The changes to the healthcare coverage for refugee claimants are significant for a number of reasons:

- This is a dramatic cut to the basic level of health coverage to some of the most marginalized and vulnerable people in Canada (sometimes, a claimant's health problems are directly related to the persecution they suffered in their home country);
- People are likely to suffer significant health risks under this new policy;
- Refugees have had federal health insurance coverage for 55 years; these cuts mark a major shift in Canada's tradition of universal health care and its humanitarian treatment of refugees;
- The changes were imposed without consulting provinces, the public or direct stakeholders;
- The changes will result in a significant downloading of costs onto the provinces and onto individual physicians who provide certain emergency services free of charge;
- The complexity of the changes, coupled with the lack of consultation, have made it difficult for the medical community to understand the cuts, and to accurately inform patients about their coverage;
- The average annual cost of the IFHP was about $552 per refugee claimant;
- Ironically, the cuts may well increase government health costs in the long run as emergency care generally costs much more than the preventive care which is being eliminated.
- Legal challenge alleges refugee health care cuts are unconstitutional

The legal challenge is being filed at the Federal Court of Canada on behalf of three patients who have had critical health care denied to them since the government cut health care coverage for refugees in June of 2012. The cuts to refugee health care are also being challenged by two public interest groups who bring additional expertise and resources to the fight: Canadian Doctors for Refugee Care, a group of doctors who treat refugees across the country, and the Canadian Association of Refugee Lawyers, a national organization of lawyers and academics who are concerned with refugee law and policy.♦

ACCESS WITHOUT FEAR

Steering Committee member Ritika Goel signed this letter February 8th, 2013 to Toronto Mayor Ford and city councillors, as part of the Access without Fear campaign, seeking action on a community services report to improve access to municipal services to undocumented persons in the City of Toronto. Councillors approved the study at their February meeting.

I am writing on behalf of the Medical Reform Group (MRG), a voluntary association of physicians and medical students who work in coalition with many community groups to address the health and medical implications of their advocacy. We have been active for over 30 years, promoting social justice and health, and advocating for high-quality publicly-funded health care for all.

Today we want to add to the voices of the Access without Fear Campaign who provided much of the information used by the Community Development and Recreation Committee in coming to its recommendations for an internal review of all city agencies, divisions and corporate units and for a community consultation to improve opportunities for improving access for undocumented people in our city.

As the committee heard from York University Professor Luin Goldring, a current best estimate of the number of workers resident in Toronto without legal status is approximately 200,000. Among the challenges faced by those without legal status are the inability to access programs and services available to legal residents and a limited ability to deal with employment-related issues. As a result, individuals who live in and contribute to our city with their labour and involvement can be and frequently are turned away from city services, subject to the whims of unscrupulous employers.

With constant new federal amendments to immigration legislation, migrants are even more at risk of detention and deportation sometimes back to a country they may only have known in childhood.

We have been very concerned in recent years that the reputation of Canada as a welcoming country and Toronto as a multicultural hub will be blighted by the new approach to immigrants. Beyond the impacts on individuals, we think it will be in the city's interest to review in more depth what contributions are made by undocumented people to our economy and the impacts of denying services of health, social services, and education.

We look forward to an opportunity for consultation on this issue, and for Toronto to lead the country and the world as a solidarity city which does not deny services on the basis of immigration status and believes in health and status regularization for all.♦

STANDING UP FOR REFUGEE HEALTH

On February 25th, 2013, Canadian Doctors for Refugee Care (CDRC) joined the Canadian Association of Refugee Lawyers (CARL), and three individual patients to ask the Federal Court to declare that federal government health cuts to refugee claimants unconstitutional and illegal.

A legal challenge has been launched in the Federal Court of Canada, arguing that the federal government's cuts to refugee health care are unconstitutional, and in breach of Canada's obligations under international law. The challenge argues that the cuts to refugee health care violate the fundamental human rights of refugees, as protected by the Canadian Charter of Rights and Freedoms, without any lawful justification. See the CARL website at refugeelawyersgroup.ca for background.

Over the past year, health providers allied with Canadian Doctors for Refugee Care have volunteered their services in a number of Canadian towns and cities to lobby for care and care for many recent refugees caught in the policy change which has reduced coverage drastically, even for those who are legally entitled to work in this country. As well, CDRC was instrumental in the design and launch of a monitoring tool—Refugee HOMES, which facilitated tracking of some of the most egregious service denials, a resource which also provided the background for the recent constitutional challenge. More information on the tool and occasional updates can be found at www.doctorsforrefugeecare.ca/

CDRC has also called for a new National Day of Action being planned for June 17th, 2013. Please check back at their website for details and plans for your town or city.♦

JOIN OR RENEW YOUR MEMBERSHIP!

USE THIS HANDY FORM

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

STUDENTS FOR MEDICARE ANNUAL CONFERENCE

You are invited to Students for Medicare's 5th Annual Conference: "Expanding the Canada Health Act: Pharmacare and Beyond"

Date: Saturday, April 27th, 2013
Location: United Steelworkers' Hall, 25 Cecil Street, Toronto

09:30 - 10:00:	Registration, Networking and Coffee
10:00 - 1130:	"Medicare: Who Should Pay and What Should They Pay For?"
	Dr. Danielle Martin, Founder & Chair, Canadian Doctors for Medicare
	Dr. Sanjeev Goel, Board Member, Canadian Doctors for Medicare:
11:30 - 12:15:	Lunch (provided)
12:15 - 1245:	Small Group Discussion
12:45 - 13:45:	"The Case for National Pharmacare"
	Dr. Marc-André Gagnon, Professor of Public Policy, Carleton University
	Author, The Economic Case for Universal Pharmacare
13:45 - 14:00:	Closing Remarks

Register at http://pharmacareandbeyond.eventbrite.com/
Lunch is provided. Suggested donation $10 or pay what you can.
Conference Co-Chairs, Students for Medicare, #SFMConf2013
William Chan and Jennifer Tung

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