# Medical Reform

*Newsletter of the Medical Reform Group*

Issue 162 Volume 33, Number 1-2 Summer-Fall 2013


# PUBLIC HEALTH CARE EXPENDITURES ARE AFFORDABLE

*Brian Hutchison*

Canada needs further investment in public health care. Among other pressing needs, we must improve primary care, establish national pharmacare and home care programs, and continue to reduce waiting lists in key areas. Progress in these investments is threatened by a chorus of warning about excessive and wasteful health care expenditures and the need for and benefits of low taxes. In this article I argue that the evidence does not support the warnings which are motivated by ideological and political considerations.

**"We Can't Afford Medicare" – New Singers, Same Old Song**

The plea for continuing investment in the health sector is frequently countered by concerns about the rising share of health spending in provincial government budgets, and more generally about rising total public and private health expenditures as a proportion of gross domestic product (GDP). Often the two are lumped together as a concern about Medicare's alleged "unsustainability," though the linkage is faulty and confused (or deliberately deceptive). Those who allege unsustainability are in fact arguing for an expanded role for private financing, user payment with or without private insurance.

These issues feature prominently in Jeffrey Simpson's book, *Chronic Condition: Why Canada's Health Care System Needs to be Dragged into the 21st Century* (Simpson 2012). Simpson worries, understandably, about healthcare "crowding out" other provincial spending such as education. His metaphors, however – health care "devouring budgets" and "money … shoveled into health care" – are calculated to conjure up images of massive profligacy and waste – mindless spending, even gluttony. Not only is Medicare economically unsustainable, it does not deserve our support. The "glutton" imagery may be hard for patients and providers to recognize, but the core of the "unsustainability" claim lies elsewhere. The central assumption is that taxes cannot or will not – or, clearly visible between the lines, should not – rise to support increased government spending on health. If more money is needed, make the patients pay.

**The Low-Tax Agenda: Social Costs, No Economic Benefit**

Although not widely advertised as such, Canada is in fact a low-tax

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## INSIDE



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

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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

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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*

A lot of the media coverage in recent months seems calculated to sour the average citizen on the state of political participation in our country. Elected officials at all levels of our political system, called to account for their blatant disregard and disrespect for citizens, turn to bevies of lawyers to exculpate themselves from allegations of wrongdoing. When that proves to be of limited effect, they shift to communications specialists to help in 'changing the channel' or parsing the semantics of fraud and conflict of interest which, in an earlier generation, would have resulted in an immediate resignation.

Still there is much to cheer as we look forward. At the end of its recent annual meeting in Calgary, both outgoing and incoming presidents seem proud to lead by example. After more than a decade of false starts, health equity now appears to be firmly on the CMA agenda. Outgoing Dr. Reid's poignant tale of finding adequate senior care for her widowed father is not yet over, but that issue ended up on the agenda of the Premiers in Niagara this summer, and it is clear that physicians can and should give leadership to modernization of this part of Medicare.

In a similar vein, 2013 President, Dr. Louis Francescutti specifically responded to last year's challenge of the governor general to acknowledge the social contract doctors have with Canadians, and embrace rather than resist change, by intensifying the focus on the social determinants of health. As noted by health journalist André Picard and others, the CMA will, for the first time collaborate seriously with other players to review carefully the value of the tests and interventions they recommend, with a focus on benefit to the patient as the primary consideration.

MRG members who have been advocating for health equity, multidisciplinary and patient-centred care since 1979, have added to the debate in a number of ways, not the least by keeping these issues on the social and political agenda and in the curriculum of medical schools, and providing a voice for the most vulnerable at times when the mainstream of the medical profession appeared to be primarily concerned with its own welfare.

This issue features a cogent appeal from Brian Hutchison for finishing the job on Medicare, an interview with medical student Andrew Bresnahan who has just spent his summer learning medicine on the Labrador coast, and many examples of how individual members have championed social justice for the most vulnerable. Later this year, we will be reviewing our mandate and hope all members will join in that debate.♦

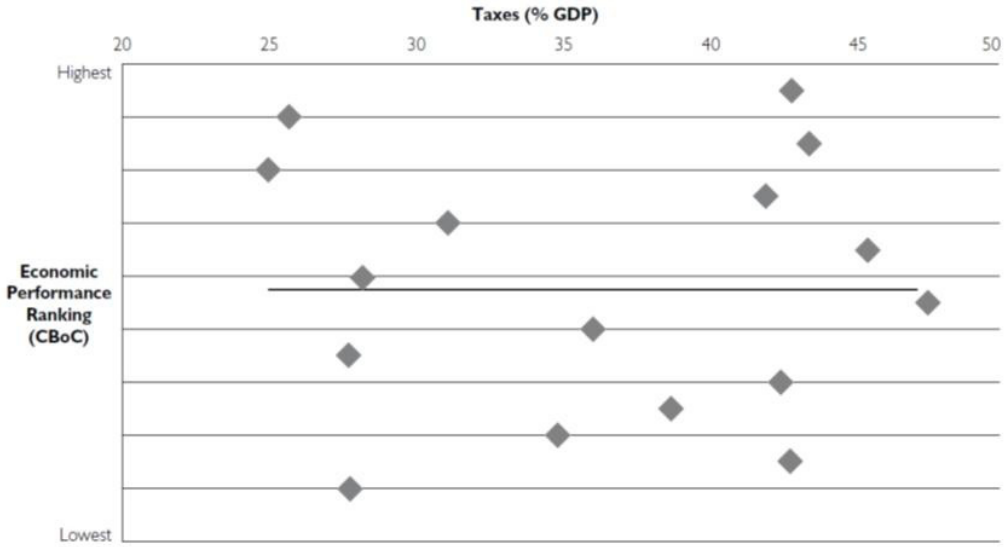
# PUBLIC HEALTH CARE EXPENDITURES (continued)

country. In 2010, total tax revenue amounted to 31% of GDP, below the 34% average of the 34 OECD countries and lower than 22 of them. Eight countries had tax revenues above 42% of GDP (OECD 2012).

Proclamations about the necessity of maintaining low taxes as a stimulus to economic growth routinely issue from editorials, op-eds, business leaders and politicians. Yet, there is no basis for these claims. In April, the Conference Board of Canada issued a report ranking the performance of 17 high-income countries in seven categories, including economic performance and social quality of life (Conference Board of Canada 2013b). Figure 1 shows the (lack of) correlation between the Conference Board rankings of economic performance and the OECD ranking of tax revenues. Could it be that low taxes are not essential to economic success after all?

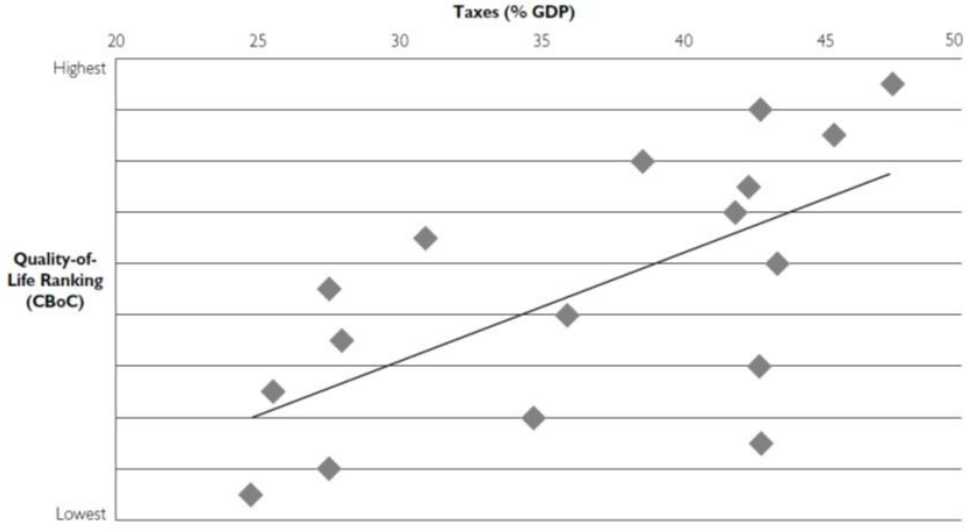
Figure 2 shows the relationship between tax revenues and rankings of social quality of life based on 16 measures. The correlation between the two, 0.642, is highly significant ($p$=.005). It appears that low taxes may incur a large social cost without an economic benefit – the worst of both worlds. But they do benefit the already well-off.

**FIGURE 1.** Economic performance ranking vs. tax revenue in 16 wealthy OECD countries




Sources: OECD 2012; Conference Board of Canada 2013b

**FIGURE 2.** Quality-of-life ranking vs. tax revenue in 17 wealthy OECD countries




Sources: OECD 2012; Conference Board of Canada 2013b

**Health Spending: Economic Drag or Economic Engine?**

Simpson views healthcare as a drag on the economy, observing with alarm its increasing share of national income. "[T]oday it eats up 11.7% of GDP" – again, the glutton metaphor – up from 7% when medicare began. But why is that necessarily a bad thing? Medicine has changed dramatically in scale and scope over the past half century, as every patient and practitioner knows. Would Simpson have us believe that there are no commensurate benefits?

Another recent report from the Conference Board of Canada (2013a) turns the "economic drag" claim on its head, describing the health sector as "an important driver of economic growth": "Health care spending in Canada *contributed* (my emphasis) 10.1 per cent of the national GDP in 2011 and supported

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# PUBLIC HEALTH CARE EXPENDITURES (continued)

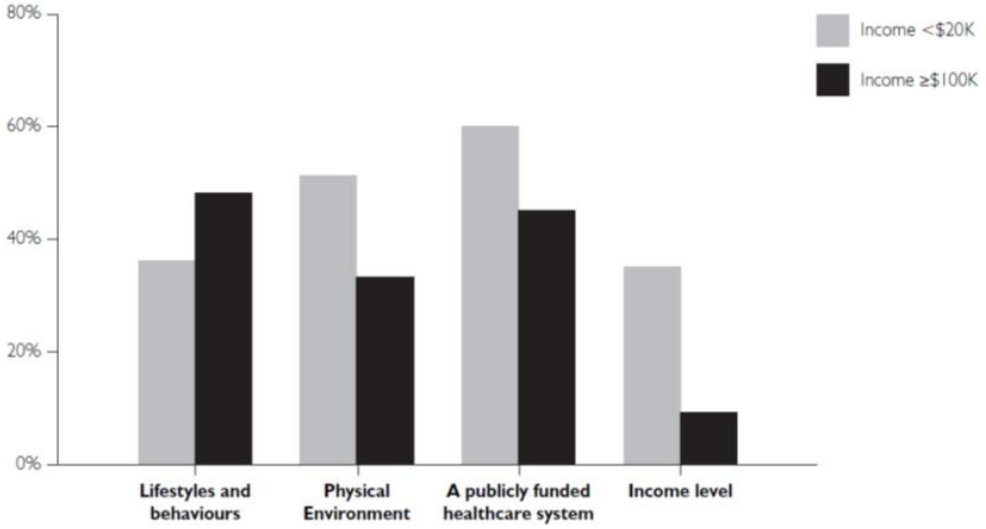
2.1 million jobs."

Ironically, the main "solutions" proposed by Simpson and his ilk to the alleged unsustainability of Medicare – a parallel private system of delivery and finance – would actually raise healthcare costs. Those with private insurance or deep pockets would obtain faster or better service outside the public system, while providers who served them would obtain higher fees and other payments. Private health insurance magnifies the cost inflation. The OECD, typically "private sector friendly," reports: "Whatever [its] role … , private health insurance has added to total health expenditures …" (OECD 2004).

The OECD (2004) also points out that in some countries "private health insurance has enhanced access to care. But such access is often inequitable, largely because private health insurance is typically purchased by high-income groups … [who obtain] shorter wait times for elective surgery. But there is no clear evidence that waiting times are also reduced in the public sector … ."

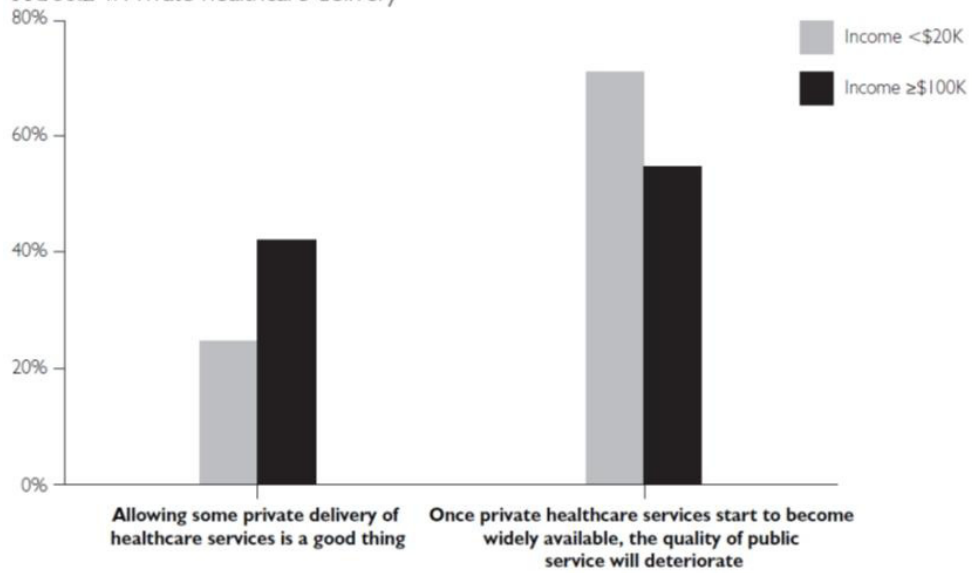
Expanding private payment would have the additional perverse effect of exacerbating income inequality, the most potent social determinant of health. The Canadian Institute for Health Information (CIHI 2013) concludes, consistent with earlier Canadian and international research, that publicly financed healthcare redistributes income from richer to poorer Canadians.

**FIGURE 3.** Determinants of Canadians' health (% rating as "extremely important")




Source: Conference Board of Canada (EKOS Poll) 2012

**FIGURE 4.** Private healthcare delivery




There is room, if need be, to increase taxes to make needed public health care investments. But facts and evidence are not the main determinants of public policy. When all is said and done, the struggles over Medicare are about conflicting interests and values.

**Forget the Evidence! Where You Stand Depends on Where You Sit**

Simpson, and presumably those he represents, calls for replacing "ideologies, inspired by vacuous slogans" with "a more functional framework of what works best at lower cost for Canadians." Few would disagree.

But proposals to introduce a parallel system of private delivery and payment would drag Canadian healthcare not into the 21st century, but back towards the early 20th. The notion that the system would be

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## PUBLIC HEALTH CARE EXPENDITURES (continued)

"fixed" by measures that would increase costs, improve access only for those able to pay and shift cost burdens from taxpayers (generally wealthier) to patients (generally less so) is more than a little bizarre. That would certainly benefit some Canadians – the same narrowly based but strategically placed interest groups that opposed Medicare in the first place and still do. Simpson speaks for them. But behind the obvious economic interests of the privatizers, there is also a real clash of values. When Simpson contrasts the "ideology" of Medicare's supporters with the supposed pragmatism of its attackers – people like himself – he just has it wrong. The clash is between competing sets of values: libertarian on the one side and communitarian on the other. The libertarian perspective in its most extreme form is captured in Margaret Thatcher's famous statement, "There is no such thing as society. There are individual men and women, and there are families." Or, as Lily Tomlin has said with tongue in cheek: "Remember, we're all in this alone."

Libertarian values include personal responsibility, unfettered autonomy and choice, small government, low taxes, personal as opposed to public spending and unconstrained opportunities for increasing individual income and wealth.

Communitarian values include shared responsibility, equality, fairness, collective rather than individual solutions to social problems, redistribution of wealth and income, and a sense of community.

But values and beliefs are not randomly distributed in the population. As shown in Figures 3 and 4, which summarize data from a 2012 EKOS poll (Conference Board of Canada 2012), they vary systematically with income. Figure 3 shows the percentage of high- and low-income Canadians who see lifestyle, the physical environment, publicly funded healthcare and income level as "extremely important" determinants of Canadians' health. Ironically, the Canadians who benefit the most from income as a determinant of health are the least likely to recognize its importance.

As seen in Figure 4, they are also most likely to support private delivery of health services and least likely to see parallel private healthcare as a threat to the public system.

The relationship between values and income means that the struggle to maintain, improve and expand Medicare as a program that embodies the core value articulated by Tommy Douglas and Emmett Hall – healthcare access and quality based solely on need – will continue to face opposition from individuals and organizations whose economic and political influence is disproportionate to their numbers. However, the line-up today is essentially the same as it was when Medicare was being debated in the 1960s. We won then, and we can win again. ♦

*Thanks to Steering Committee member Gordon Guyatt for preparing this excerpt from The Undisciplined Economist column in the most recent issue of Healthcare Policy (Hutchison B. Reforming Primary Care - Don't Stop Half-Way. Healthcare Policy 2013;9(1):12-25). The full text of the article can be found at www.longwoods.com/content/23489.*

# ONTARIO POVERTY REDUCTION STRATEGY

When the Ontario government enacted its poverty reduction strategy, it also provided an accountability mechanism which required it to report and consult with Ontarians this year. In late August, Toronto members of the 25 in 5 Coalition which advocated for the accountability in 2008 met for a preliminary assessment of the government's progress on this file.

Early indications from the government are that the Ontario Child Benefit has succeeded in lifting nearly 100,000 Ontario children out of poverty since 2007. However, prospects for some of the most vulnerable continue to be dismal. Much of the regulatory change which is being undertaken as part of the poverty reduction strategy is very difficult to track adequately, but the Income Security Advocacy Centre, allied with the community legal clinic network, expects to release a series of fact sheets shortly, including one on drug benefits. The Coalition is planning to organize a community-led consultation tentatively set for the evening of Tuesday, September 24th, 2013.

For more information on the plans as they become public, and on accountability sessions planned for elsewhere in the province, contact Janet Maher at medicalreform@sympatico.ca ♦

# HOME CARE: WHAT WE NEED TO KNOW

*Janet Maher*

For nearly 20 years now, our health system has been progressively restructured to deliver only the most complex acute care in hospitals or other clinical settings, and this has resulted in a significant decrease in hospital beds, but without a commensurate increase in services to support those released before their rehabilitation is complete or whose admission is avoided.

As a result many families are forced to provide much more, often relatively complex, care to their loved ones. Increasingly, families are also being asked to bear costs that would have been part of Medicare in the past, basically because the services are delivered outside of the hospitals or clinics whose services are publicly funded.

**What is home care?**

Home care refers to a very broad range of therapies and services, delivered by both regulated health care providers and unregulated workers that collectively allow patients of less acuity to be cared for outside of expensive acute care services. These therapies or services may be delivered to patients in their homes, but they are often delivered in retirement homes, rehabilitation and long term care settings. Typical services include administering certain medications, physiotherapy, occupational therapy, speech therapy and respiratory therapy. General nursing care includes wound or fistula care, administration of drugs or other measures to relieve pain. The third large category of service is what is euphemistically called personal service—assistance with the activities of daily living, from assistance with personal care and hygiene, cleaning, shopping, and accompaniment to medical or rehabilitation appointments.

**How is home care delivered?**

Prior to about 1990, in the days before Community Care Access Centres, a range of voluntary associations had grown up in most communities, and often made agreements on a not-for-profit basis with individual hospitals or their discharge planners to provide some of the specialized services that would allow those patients who were able or ready to be released from hospital. Among the agencies well known for community service of this sort were St. Elizabeth's Nursing, the Victorian Order of Nurses, the Visiting Homemakers Association, and the Kidney Foundation.

Through the 1990s, as governments began seriously to try and cut acute beds, a succession of intermediary agencies were developed with the objective of managing allocation of home care services with the exception of physician services.

The current configuration of those services in Ontario occurs in Community Care Access Centres, a structure which was designed to respond to local needs by contracting with and monitoring the delivery of the full range of services we know today as home care. Until about 2003, those centres were directly funded by the province according to a population-related formula, and then negotiated with potential providers in their communities to deliver a given mix of services to the maximum budget they had been allocated.

Between 2004 and 2007, in Ontario, responsibility for the Community Care Access Centres (CCACs) was devolved to the newly-established Local Health Integration Networks (LHINs) as the McGuinty government moved to delegate responsibility for health-related decision making to the local level. The annual health allocations to the LHINs are intended to cover the full range of services necessary to maintain an individual in good health—including where appropriate, emergency and acute care in hospitals, rehabilitation and palliative care in specialized clinics, and personal supports for daily living in long term care, assisted living and individual homes.

Currently, individual patients get access to publicly funded home care services on the basis of an application to the local CCAC. Depending on their assessed need and the particular mix of services the CCAC is equipped to provide, an individual will be allocated one-time or ongoing service which may include some of the specialized services, general nursing care or personal support services. Physician care continues to be delivered where appropriate according to the province's agreement with the Ontario Medical Association.

**How Does Home Care Work for a Patient?**

The provision of home care across Canada is a real patchwork of rules and regulations outlining means testing, user fees, and various limitations, monthly or episodic maximums and exclusions. In general medical and general nursing services are more available without direct fees or with minimal direct fees, whereas personal support services are both less available and generally charged for. As a result of the so-called Health Accord, signed by the Martin government in 2004, access is markedly better for patients in a two-week post-acute episode window; in most cases, no means testing and no direct fees are the norm.

In most cases, eligibility for services is typically determined and allocated by an intake worker who takes the referral at the responsible care

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# HOME CARE: WHAT WE NEED TO KNOW (continued)

agency—in Ontario, the Community Care Access Centre (CCAC)—according to a protocol which varies from one community and one province or territory to the next, and which is typically open to appeal. Following its assessment, the CCAC informs the patient or her caregiver of the result, which normally will outline the kind of service, expected time, frequency, and duration and fees if any. As soon as these details are confirmed, the CCAC then contracts with an appropriate agency on its roster to ensure services are delivered as agreed.

**What are the issues?**

In a draft summary from a 2009 Statistics Canada publication circulated February 12, 2013, the Ontario Health Coalition characterized unmet need in the following terms:

- 4% of seniors reported at least 1 unmet need from professional home care services. This number is generally consistent across all provinces.
- Close to 63% of these seniors attributed this problem to personal circumstances (inability to pay), 24% cited features of the health care system (lack of service availability, not qualifying for services), and 13% claimed a combination of both.
- Housework and personal care were the 2 most common unmet task needs for seniors
- Women are more likely to report unmet need (5%, vs. 3% for males).
- Severely disabled individuals were less likely to receive adequate services (10% with unmet needs, vs. 1% of those with no disability).
- Among those with severe personal care or mobility needs the percentage with unmet needs is 20% and 29% respectively (compared to 3% and 4% among seniors with no limitations)[1]

Additional issues identified by the Ontario Health Coalition include:

- Complaints about poor coordination at transitions in care (discharge from one type of care to another) which leaves vulnerable individuals in limbo
- Adequacy of allocations to meet need in a given area
- Variability of services covered because of devolution to the LHIN
- Immediate threat in 2013 budget announcements to consider home care user fees on a similar basis to ODB co-payments.

**What has the government done?**

In January, 2013, the Minister of Health and Long Term Care announced the release of a provincial strategy led by Dr. Samir Sinha, in which user fees would be an option. Highlights of the Sinha report, Living Longer, Living Well included:

- Top 10% of older Ontarians account for 60% of health spending for those over 65; healthiest 50% of population accounts for 6% of health care spending on older adults
- Support for health and wellness in the community including Elderly Person Centres, accessible exercise, falls prevention, and health promotion programming across Ontario
- Acknowledge difficulties of low-income older adults to live well
- Ensure all older adults have access to primary care, including funding for house calls where appropriate
- Coordinate care between CCACs, Community Support Services and Community Mental Health Agencies
- Link housing and transportation supports to health care where appropriate
- Hospitals need to do more to be Senior-Friendly with specific accountability agreement measures
- Expand community paramedicine programs
- Explore using LTC homes as hub for community services including home care to assist Aging in Place
- Review application and transfer processes to and from LTC homes
- Review HHR and professional development to support best practice care for regulated and personal support workers
- Support safer prescribing for older Ontarians
- Address elder abuse and neglect

**What else can be done?**

Optimal for patient care would be the integration of home care and pharmacare as part of the continuum of care and as covered services under the Canada Health Act, with public accountability through a mechanism similar to the current provisions of the Canada Health Act. In the meantime, it would make sense to consider a policy framework/test or mechanism to assess potential savings vs costs of acute care readmissions and a strategy for directing these savings to the improvement of current services.

In early 2013, the Ontario Health Coalition identified the following priorities for Ontario:

- Stop competitive bidding
- Fund to meet population needs for services
- Build needed capacity across the continuum of care[2]

*See correspondence elsewhere in Issues 161 and 162 for MRG collaboration in calling on the Ontario government to reconsider user fees for home care.*♦

1. Statistics Canada, Seniors' use of and unmet needs for home care, 2009 (by Melanie Hoover and Michelle Rotermann).

2. For more information see the Ontario Health Coalition website at www.web.net/ohc/Homecare.htm

# MRG ENGAGES IN 2013 FEDERAL PRE-BUDGET CONSULTATIONS

*On August 5th, 2013, the Medical Reform Group participated in the House of Commons Standing Committee on Finance online budget consultations with the following recommendations.*

**Recommendation 1: A Comprehensive Pharmacare Strategy for Canada**

The cost of prescription drugs has been one of the principal cost drivers in the health budget over the past 20 years. The provinces and territories have made significant progress in the past 5 years in beginning to reduce the cost of pharmaceuticals and medical devices to Canadians. What is needed now is system-wide coordination and facilitation best implemented at a pan-Canadian level, to ensure that additional improvements benefit all equally. We foresee a framework and structure that could support collaboration with all regions to enhance the evidence base for a comprehensive pharmacare strategy, and leadership with private and public sector partners to design and implement a strategy to reduce drugs costs for residents from all walks of life.

**Federal Funding Proposed:**

The federal department of finance is best positioned to determine the balance between more effective use of existing resources and new spending, as it is estimated that more comprehensive drug coverage would not only improve Canada's market competitiveness and our overall health but also reduce rates of poverty and social inequality. A relatively small investment of $10 million per year for the next 5 years could provide for significant federal level project monitoring, possibly some pilot projects to realign, for example, private and employer insurance and all the public sector benefits plans (seniors, rehab services, social assistance recipients, etc.)

**Intended Beneficiaries:**

A comprehensive strategy would expand publicly supported coverage from a limited number of designated groups to all residents of the country, and be designed to ensure coverage for all and cost no more in the short term than all existing drug expenditures. Over the next 5 to 10 years, a revenue plan could be devised to provide first-dollar coverage (without copayments or deductibles) for all.

**General Impacts:**

Assured access for all to medically necessary drugs would improve the health status of all, with lower long term costs to the federal treasury and would also improve the ability of Canadians to be involved in the economy, including adding to revenues through personal taxes.

**Recommendation 2: Restoration of Interim Federal Health Benefit**

The interim restoration and enhancement of refugee health coverage benefits for all those living in Canada is a humanitarian public health measure which will contribute to the health security and health status of all by ensuring high quality medically-necessary care for all conditions regardless of the individual situation of the patient.

**Federal Funding Proposed:**

In the short term, we recommend the restoration of the Interim Federal Health Benefit to all at a cost of approximately $20 million annually; in the medium and longer term the costs of this program related to drug benefits would be integrated into the pan-Canadian pharmacare strategy.

**Intended beneficiaries:**

As above, this recommendation would benefit all residents in our country regardless of status or origin. Refugees would benefit directly, whereas the health status of all would be improved with a seamless provision of care to those who do not meet the current provincial/territorial requirements for coverage.

| | Recommendation 1 | Recommendation 2 | Recommendation 3 |
|---|---|---|---|
| **Topic** | Health | Health | Business taxation and regulatory issues |
| **Expected Savings** | >$1 billion | $1 to $10 million | $1 to $10 million |
| **Timing of Investment or Savings** | Immediate, with effects 5+ years into future | Immediate, with effects 5+ years into future | Immediate |

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# MRG PRE-BUDGET CONSULTATIONS (continued)

**General impacts:**

As with proposal for leadership on a national pharmacare strategy, improved health status is likely to be associated with an improved standard of living and an increased ability of the population to contribute to general tax revenues.

**Recommendation 3: Enforce the Canada Health Act**

The Canada Health Act was introduced to increase accountability for the investments taxpayers make in publicly funded and administered for all, by enumerating conditions for provinces and territories to receive health care funding. Although successive annual reports have reported on a broad range of violations, in recent years little has been done to either discourage persistent violations or to encourage more effective use of public resources in advancing health for all. We believe accountability is a central requirement for all government programs and should be reinstated following the example of former Health Minister Diane Marleau.

**Federal funding:**

The federal department of finance is best positioned to determine the balance between more effective use of existing resources and new spending. A relatively modest investment of $10 million per year for the next 5 years could provide the design and implementation of a comprehensive monitoring structure to ensure that all Canadians get value for money in our health investments.

**Intended beneficiaries:**

Everyone in all parts of the country.

**General impacts:**

This measure should be part of a comprehensive approach to accountability for public investments.

**Conclusion**

We believe our proposals are consistent with a budget approach which seeks accountability for all current investments, and will begin to offer the kind of leadership all Canadians are seeking from the Government of Canada.

In the areas of health services in which many of our members are acknowledged international experts, we would be pleased to offer more specific recommendations as you proceed with implementation. ♦

# A STEP IN THE WRONG DIRECTION FOR DRUG POLICY

The Medical Reform Group (MRG) today denounced the Federal Government's decision to pursue further ideologically-based legislation against supervised injection sites.

"Too often, ideology trumps evidence in health policy decisions," said MRG spokesperson Dr. Reed Siemieniuk. "The Harper government is dismissing compelling evidence of the public health benefits of supervised injection sites by choosing to pursue ideology-based legislation."

Since the establishment of Insite, Canada's first supervised injection site, a second site has yet to open its doors despite evidence that a supervised injection site would benefit cities like Toronto, Ottawa, Victoria, and Montreal. However, the Conservative government tabled a bill yesterday that will put an unreasonable burden on community groups. As worded, the proposed amendments would effectively give the Harper Government a veto over any new proposal.

"The bar is already set exceedingly high for establishing a supervised injection site," said another MRG spokesperson, Dr. Michael Schwandt. "People who inject drugs are desperately in need of health services and we have evidence-based, cost-effective answers. One large missing piece is a government willing to help implement these solutions."

Physicians see the effects of injection drug use on a regular basis. The current criminal response to drug use tends to further marginalize people who use drugs.

"This is a step in the wrong direction for sound drug policy," said Dr. Siemieniuk. "By pursuing this legislation, our Government continues to demonize some of Canada's most vulnerable people based on outdated beliefs. Beyond preventing drug-related deaths, HIV infections, and hepatitis C infections, evidence shows that supervised injection sites tend to be associated with increased safety for communities," Siemieniuk added. ♦

*Released by the Medical Reform Group, June 7, 2013*

# BRIDGING THE GENERATION GAP

*Earlier this summer, MEDICAL REFORM asked student member Andrew Bresnahan to talk about his background and approach to health care advocacy.*

**MEDICAL REFORM**: Can you tell me a little about yourself and how you decided to go to medical school?

**AB**: I was born in Labrador, and grew up in Ontario with a sense that what I saw around me wasn't the only part of Canada or the world that exists. I think this really inspired an openness to peoples' stories, and was a big part of why I chose to pursue undergraduate and graduate studies in anthropology – which deals with pretty ambitious questions about the unity and diversity of our species, the relationships between global patterns and individual lives, and how we think about health and social justice.

I became interested in medicine in part because I could see that every disease has a social story. I think medicine offers a unique opportunity to hear these stories, to help us learn to see the bigger economic and epidemiologic patterns that shape the distribution and determinants of health. I'm also attracted to the very pragmatic focus of clinical practice, and still see it as a good way to ground the epidemiologically more vital work of working with patients and communities to change the conditions that make people sick, and build a more healthy society.

**MEDICAL REFORM**: I know you already have a Master's in public health. How has that contributed to your approach to medicine? Where do you think it will lead you?

**AB**: At its best, improving population health is really what medicine is all about. Whatever our specialty, wherever our practice, we have reason to work alongside our patients and communities to improve the conditions of everyday life, tackle the inequitable distribution of power, money, and resources, and assess the impact of action (to borrow language from the WHO Commission on Social Determinants of Health).

Studying public health – especially epidemiology and biostatistics – has certainly helped me build a better toolbox of methods for understanding communities. I also used my public health studies as an opportunity to learn what other countries are doing to advance health equity, with special attention to lessons from the Nordic countries and the impacts of social democracy on social determinants of health. I know I'll be drawing on these lessons throughout my life as a physician, and as a community organizer.

**MEDICAL REFORM**: What skills do you think you have learned in medical school and elsewhere that shape your analysis of the role of health care and health care providers in society?

**AB**: Working in public health has given me the chance to work with friends and colleagues from right across Canada, but I've always felt drawn back home to Canada's north.

In 2009-2010 I worked with the Public Health Agency of Canada (PHAC) and with the Inuvialuit and Gwitch'in peoples in the Northwest Territories to better understand the social determinants of health in Canada's north. In 2011, I worked with a team of physicians and public health nurses from Labrador-Grenfell Health and the Nunatsiavut Government to build a tuberculosis (TB) database for the Labrador coast, and am back in Labrador now for a summer of family and emergency medicine.

And in 2011-2012 I worked with the National Collaborating Centre for Determinants of Health (NCCDH) and Medical Officers of Health from across the country to better integrate health equity indicators into population health status reporting in Canada. As part of this work, I joined Inuit public health leaders from across Nunavut to promote the roles of Inuit Qaujimajatuqangit (Inuit knowledge) and science in building health communities. I'll be heading to Nunavut and back home to Nunatsiavut this winter to continue building a better understanding of Inuit Quajimajatuqangit, and how best to practice medicine and public health in the North.

These experiences have really enriched my relationships with colleagues, friends, and family up North, and given me a better appreciation of organization of health systems from coast to coast to coast, and the remarkable work people are doing to help build a healthier and more just society for all Canadians.

**MEDICAL REFORM**: What do you see as the links, if any between health, human rights and poverty, in general and in your approach to your future as a clinician?

**AB**: I think the most important determinant of health is how much control we have over our lives. The conditions of everyday life – our relationships, income, housing, education, where we work and play – profoundly shape our capabilities, and our ability to shape them in return is a powerful measure of our freedom. Nobel Prize-winning economist Amartya Sen brilliantly describes poverty as capability deprivation – as con-

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straints on our ability to be and do things that we value – and I think that's a helpful way to think of it. Income is important, but more than anything it's a proxy for our control over our lives.

Because it's so widely recognized and institutionally supported, the language of human rights is a powerful way to talk about social justice. But we should always remember that human rights are not natural facts, but claims to justice, ethical ideas about what is right. In the same sense, the idea of human rights is at best instrumental for changing material conditions. Building a more coherent legal and policy environment is not the goal in itself – at their best, better laws and policies are tools for changing the conditions of everyday life in ways that give people more control over their lives and their health.

A commitment to health equity involves working to improve overall population health while reducing avoidable health inequalities within and between communities. Practically, I think this goal is best served by what physician and medical anthropologist Paul Farmer calls "pragmatic solidarity" – a commitment to working alongside the destitute sick, and against the political and economic structures that cause and perpetuate poverty and ill health. I hope that my practice can reflect this commitment, and contribute in practical ways to building a more healthy and equitable society.

**MEDICAL REFORM**: What do you see as the 2 or 3 main policy issues for current medical graduates? What do you think your work will look like in five years or so?

**AB**: I think the most vital policy challenges facing current medical graduates relate to health equity, and are nicely articulated by the WHO Commission on Social Determinants of Health in its overarching recommendations to 1) improve daily living conditions; 2) tackle the inequitable distribution of power, money, and resources; and 3) measure and understand the problem and assess the impact of action.

Overall, Canadians enjoy good population health outcomes relative to our international neighbours. But national averages obscure steep gradients of health inequity. I study medicine at McMaster University in Hamilton, a city with a 21-year difference in life expectancy between its wealthiest and poorest neighborhoods. Across Canada, Inuit, First Nations, and Métis peoples too often face low incomes, high food prices, poor housing, barriers to education, and inter-generational trauma. And last year's changes to refugee health policies in Canada highlight yet another gradient of health, along lines of citizenship. None of these differences in health status are necessary; they're both unacceptable and avoidable. We can do better.

We've never had a better toolbox of evidence, practices, and policies at our disposal for advancing health equity. Much of the scientific case for improving daily living conditions and reducing health inequities is elegantly summarized in Sir Michael Marmot's work, including his book The Status Syndrome (2004) and the WHO Commission's Final Report (2008). At the clinical level, I find Dr. Gary Bloch's "Clinical tools for addressing poverty in primary care practice" (2013) helpful for showing that it's possible to apply this evidence in clinical practice, by screening, adjusting risk, and intervening to help low-income patients gain more control over their lives. At the policy level, Ryan Meili's A Healthy Society (2012), Dennis Raphael's Tackling Health Inequalities (2012), the Swedish National Institute for Public Health's Health for All? (2008), and Michael Rachlis' Prescription for Excellence (2004) are each rich with examples of healthy public policies – from affordable childcare and accessible green space, to equitable financing and democratic reforms – that can inspire a sense of evidence-based optimism, and help us mobilize the social movements we need to bring the best of these ideas to life.

Drawing this evidence together and making a winning case for action is one of the greatest challenges for our generation. Part of this challenge is to improve our systems of health informatics – our systems of data acquisition, organization, access, and application in medicine and public health. Better electronic medical records, public health surveillance practices, and population health assessments can improve our understanding of population health problems and assess the impacts of action. Another part of this challenge is to translate this information into language that's meaningful to the public. Having the evidence is just a step in the right direction – it's public action that brings the evidence to life.

**MEDICAL REFORM**: What implications does this have for advocacy more generally and do you see yourself involved there?

**AB**: In the past year, the urgency of equity has become more and more a central part of conversations about health in Canada's medical community. As the keynote speaker at last year's CMA meeting in Yellowknife, Sir Michael Marmot reminded Can-

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# BRIDGING THE GENERATION GAP (continued)

ada's doctors that "social injustice is killing people on a grand scale." At the same meeting, the CMA released a paper on health care transformation in Canada, urging physicians to take action to advance health equity. And this summer, the CMA released the results of its town hall series "What Makes us Sick", reporting that Canadians highlighted four main determinants of health: income, housing, nutrition and food security, and early child development. Going a step further, the CMA recommended that Canada adopt a national Pharmacare program, a "Housing First" approach to homelessness, a national food security program, and a guaranteed national income. This mainstreaming of health equity shows that advocacy for action on the social determinants of health is making a difference. It also presents an obvious challenge – to bridge the gap from ideas to action, with the goal of actually improving daily living conditions, advancing equity, and assessing the impacts of action.

In the past few months, I've seen first hand some positive steps in this direction. This spring I joined the general assembly of the Canadian Federation of Medical Students (CFMS) in Quebec City as we unanimously passed landmark position papers on the Social Determinants of Health and Refugee Health. In June, I joined dozens of my fellow medical students from McMaster and thousands of physicians, health professions, and fellow medical students across Canada for the National Day of Action for Refugee Health, calling on the Federal government to reverse its cuts to health insurance for refugees. And this summer, I again worked alongside Inuit colleagues who are designing and delivering public health programs in their own homeland through the Nunatsiavut Government, an achievement of self-determination.

What generation has ever come of age without great work to be done? We have lots to do together to heal the ongoing trauma of colonization, to achieve truly universal access to health care, and to translate evidence and policies about health equity into public action for a more just and healthy society. After another summer in Labrador, I'm all the more committed to sharing in this work. This year I look forward to continuing to study medicine, while working to improve our curriculum so that future doctors are better equipped to advance health equity. I also look forward to working with the Medical Reform Group and Canadian Doctors for Medicare to encourage innovation within Canada's public health care system. And more than anything, I look forward to coming back north to Nunavut and to the Labrador coast to continue working alongside my friends and colleagues this winter.

When I look around me at the people I get to share this work with, I feel deeply lucky, and more inspired than ever to keep learning and practicing. ♦

# CANADIAN PHYSICIANS CALL FOR RELEASE OF EMERGENCY PHYSICIAN ARRESTED IN EGYPT

*At press time, Loubani and Greyson have been in prison for 2 weeks. A hearing with the Egyptian prosecutor on August 29th, 2013 did not take place as scheduled, and there has been no further news from Egypt.*

It has been over 48 hours since Dr. Tarek Loubani, an Emergency Room Physician from London, and Canadian filmmaker John Greyson were arrested by Egyptian authorities. Dr. Goel, an MRG spokesperson and friend of Dr. Loubani states, "Dr. Loubani is well-known and respected as a physician who is very committed to his patients and to broader matters of social justice."

The two Canadians were headed to Gaza where Dr. Loubani has previously provided medical care when a stop-over in Egypt led to their unexpected arrest. Their detention by Egyptian authorities is especially concerning given the state's record on human rights violations as well as recent political unrest leading to many casualties.

Goel goes on to state, "It is completely unacceptable that Dr. Loubani and Mr. Greyson should continue to be detained. The Canadian government must do everything in its power to get them free." ♦

*Released by the Medical Reform Group August 19, 2013. For more current information, members may want to consult the blog of Justin Podur, a friend of the two, at podur.org, or follow him on twitter at @justinpodur.*

# WHY DO DOCTORS STILL THINK PHARMA DOESN'T INFLUENCE THEM?

*Ritika Goel prepared this item originally for Huffington Post where it was posted April 2nd, 2013 and Healthy Debate, where it appeared April 8th, 2013.*

Why do so many doctors still think they are invincible to the influence of the pharmaceutical industry? Attractive, well-dressed, charismatic drug reps with pearly smiles and shiny flow charts still wait in waiting rooms. Lectures and conferences still occur where lunch is paid for by the pharmaceutical industry. Research studies are still published where investigators receive grants from drug companies and unfavourable results are still buried. Hospitals and medical clinics are still awash in brochures, pens, notepads and coffee mugs sporting names like Pfizer and Lipitor. This doesn't even include free drug samples lining backroom shelves. How can all this still be permitted given that patients come to their doctors expecting to be offered unbiased health advice?

From the pharmaceutical industry's perspective, this makes perfect sense. The bottom line for any for-profit company is to sell their product, and since they can't sell drugs directly to patients, they convince doctors to prescribe them. The more a doctor sees or hears the name of a drug, whether through drug reps, brochures or seeing the name on stationary, the more likely the drug is to be prescribed.

Knowing that doctors turn to published literature and lectures to make their decisions, pharma provides grants to researchers and funds conferences. Accepting free drug samples is one of the more contested issues among doctors. While doctors may see this as an act of charity by drug companies, which will benefit their patients living in poverty, it is actually just another way of increasing familiarity with drugs. When a doctor gives a patient a drug sample, she has to learn the name, dosing and side effects of the drug. Even though the sample is free at first, once a patient's condition is well-controlled with this medication, the doctor is more likely to keep using this drug since it "already works for the patient." She is also then more likely to prescribe it to other patients because she remembers the details of the drug. In a market where the newest drugs are usually just slight variations on existing products, this type of familiarity is essential to pharmaceutical sales.

So it makes sense why the companies would do this, but why would doctors not resist these practices? In 2007, a national survey of doctors in the US found that 94% had some form of relationship with the drug industry. While 28% reported directly receiving payment for consulting, lecturing or enrolling patients in a study, a striking 78% reported receiving drug samples and 83% reported receiving food in their workplaces.

When considering the impact of these relationships, two-thirds of medical school department chairs in the US felt a relationship with the industry had no impact on professional activities (and almost two-thirds reported having such a relationship). It is then perhaps unsurprising to note that medical school provides substantial contact to students with pharmaceutical companies, and the more contact they have, the more likely they are to think that such contact does not influence their prescribing behaviour. In a study of medical residents, 61% felt their prescribing behaviour was immune from drug promotions but interestingly, only 16% felt this way about the prescribing of other physicians. This means that doctors think they can't be influenced, but obviously acknowledge that others can.

When it comes to the research, there is no question that doctors are in fact influenced. A review from 2010 finds that information provided by drug companies (drug reps, journal ads, pharma-sponsored events, participating in pharma-funded clinical trials and more) all led to an increase in prescribing the promoted drug.

An earlier review also found that after meeting with pharma reps, doctors were more likely to ask their hospital to add the company's drug to the formulary. When it comes to the influence on research, a systematic review looking at studies funded by pharmaceutical companies found that these were less likely to be published, meaning less transparency, and if they were published, they were more likely to have outcomes favouring the sponsor than were studies with other sponsors. At the end of the day, whether or not doctors recognize that their prescribing behaviour is influenced by the presence of the pharmaceutical industry, it is the patient that suffers by receiving biased advice, and both the patient and the broader system that pays for unnecessarily expensive newer drugs

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# WHY DO DOCTORS (continued)

when often cheap generic alternatives may work just as well.

Canada has banned the use of TV, print and radio advertising of drugs directly to consumers because we recognize that this information should come from unbiased sources. Why then do we allow so much drug promotion to physicians? As a medical community, we have to say no to pharmaceutical influences on our practice -- this means banning drug reps from our offices, samples and promotional products and avoiding lectures and conferences funded by pharma.

We have to work to make our medical schools "PharmFree" following the lead of the American Medical Student Association. We have to support and fund independent bodies that review medical literature untouched by pharma such as the BC Therapeutics Initiative and support educational events that strive to be pharma-free like the BC College of Family Physicians' Annual Conference.

We have to work to require all clinical trials to be published so we are aware of all the evidence, not just some of it. As doctors, we have to do this for our patients, and as patients, we have to demand this of our doctors. And if ever we find ourselves feeling skeptical about the impact of the pharmaceutical industry's efforts on physician prescribing behaviour, we have to remind ourselves, they wouldn't pay for it if it didn't work. ♦

# HEALTH CANADA CONSULTATION ON PLASMA DONATIONS IN CANADA

*Earlier this year, Canadian Plasma Resources, a Toronto-based for-profit blood collection facility, began the process of seeking approval to open two sites for the collection of plasma from paid donors. This represents our submission to the formal Health Canada consultation process on July 26th, 2013.*

**Executive summary**

The Medical Reform Group, a voluntary association of physicians and medical students committed to improving access and equity in publicly funded not-for profit health care, is pleased to take this opportunity to express our concerns relating to plasma donation in Canada.

The brief points out our concern that we believe that authorizing plasma collection from paid donors is contrary to Canadian values. Moreover, we note that no comprehensive business case has been advanced to demonstrate either the need or the value of collection facilities for plasma collection at this time, and so we recommend no further action on the request of Canadian Plasma Resources until and unless such a business case and supporting documentation is presented to all identified stakeholders. In the interim, we would recommend that the relevant federal and provincial-territorial authorities continue to review and update health protection regulations to ensure that Canadians can rely on all health-related products and devices deemed medically necessary.

**The Medical Reform Group and our main issues**

The Medical Reform Group is a voluntary association of physicians and medical students which has advocated for over 30 years to improve our health by monitoring the provision of public health care, and promoting equity and social justice. Over the years, we have advocated for maintaining and enhancing public infrastructure on a not-for-profit basis, addressing the high costs of drugs and medical devices by lobbying for a pan-Canadian pharmacare strategy, more effective use of multi-disciplinary teams in primary care and of enhanced home care as a smart solution to acute bed shortages. We welcome this opportunity to explain our concerns and recommendations about plasma donations in Canada.

**Background**

Earlier this year, a private company, Canadian Plasma Resources, expressed an interest in opening two plasma collection facilities that would compensate donors in downtown Toronto. Following an initial consultation with selected stakeholders, Health Canada agreed to expand its public consultation on the issues raised with this request, and we are taking the opportunity to express our views and concerns.

As with many other health-related issues, jurisdiction on the plas-

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# HEALTH CANADA CONSULTATION (continued)

ma collection is split between provincial and federal levels, so that the province is responsible for whether donors are to be paid, and for the regulation of other commercial decisions relating to such a practice, whereas the federal government has the authority to ensure the safety and efficacy of the collection facility and the health products made there.

This paper outlines our concerns with respect to both safety and efficacy as well as ethical and commercial decisions, and we will submit our concerns to the Ontario Minister of Health and Long Term Care.

**Commercial**

The business case for Canadian Plasma Resources has not been made public, and little evidence, most of it contradicting the premise of a business need or processing capacity in Canada, was presented at the initial limited Health Canada consultation in April, 2013.

Canadian Blood Services (CBS), one of the stakeholders at the April consultation indicated that there is no current demand for additional plasma products, beyond those already available from international suppliers. Moreover, CBS notes that, as a not-for-profit entity with considerable experience in blood services, the investment in the specialized fractionator required for processing the products would only be viable with a collection capacity of 600,000 to 700,000 litres a year, a volume not likely to be approached by Canadian Plasma Resources with its current business plan.

We therefore recommend that, until and unless a clear business case can be demonstrated for value to be added with a Canadian processing facility, no further consideration be given to approving such a facility for licensure in Canada.

**Ethical**

Blood products are similar to other human tissue and body parts and not commodities to be bought and sold. Where various kinds of tissue is donated, for example, blood, bone marrow, kidneys or other organs, strict conditions are imposed to ensure the donation is completely voluntary and poses the minimum risk both to donor and recipient.

Given the long history of voluntary donation in most parts of Canada, we are furthermore concerned that implementation of a system of payment for some blood donations could either erode the current voluntary donor pool, and/or distort the supply in other ways.

We therefore believe that payment for blood products should not be allowed at this time, even if a business case were made that suggested this to be financially viable.

**Safety and Efficacy**

Health Canada has been exceptionally diligent since the Krever Commission report of 1998 in addressing all the product safety issues identified at that time. Moreover, as technology has improved, the Canadian Blood Services has been quick to adopt best collection practice protocols and so there has not been a repeat of the tainted blood scandal of a generation ago.

In the earlier limited consultation, Health Canada acknowledged some gaps in its surveillance system. We are also concerned that the shift in the regulatory approach from health protection to health risk management and reliance on self-inspection, does not necessarily provide the degree of safety expected by Canadians. This is further exacerbated by the Canadian Plasma Resources proposal to locate their first two collection facilities in inner city areas where the consideration of financial benefit may trump that of product safety.

We therefore recommend no change from the current practice of voluntary collection and distribution of blood products by Canadian Blood Services/HemaQuébec, and continued purchase of duly inspected product from international suppliers using Canadian voluntary donors.

Our proposals:

**Recommendation 1**.

Any proposal to change the current practice of voluntary donation of blood and other body parts/organs must be supported by a comprehensive business case of the risks and benefits to all identified stakeholders.

**Recommendation 2**.

Even in the situation of a supportive business case, payment for blood products is contrary to Canadian values and practice, and should continue to be prohibited on ethical grounds.

**Recommendation 3**.

Given the concerns around safety and efficacy, Health Canada should continue to enhance its regulatory approach to guarantee the continuing high quality of blood and other health-related products as a preventive measure. ♦

# CALLING ON ONTARIO TO DENY APPROVAL FOR PAID PLASMA DONORS

*At the same time as we prepared our submission on plasma donation for Health Canada, Dr. Gordon Guyatt wrote Ontario Health Minister Deb Matthews on July 26, 2013, calling on her to deny a licence for for-profit plasma collection.*

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.

We were pleased to see in March, 2013, that you urged Health Canada not to license such a facility without consulting widely on the issue when the issue of recruiting paid donors to a for profit plasma collection clinic first arose in the Toronto media.

We attach a copy of our submission to the expanded Health Canada consultation and would also urge your government to complete its due diligence on the matter. In particular, we understand policy responsibility for allowing the recruitment of paid donors for any health-related issue such as this is in the hands of the provincial and territorial governments.

As we note in the brief, we have ethical concerns about payment for blood, tissue, or other human organs, and although payments have been authorized for related services, with stringent conditions to ensure the voluntary nature of the transaction and protection of the privacy of donor and recipient, to our knowledge, Ontario does not and should sanction payment for blood or other human tissue products.

We are also concerned that no comprehensive business case has been offered so far by Canadian Plasma Resources regarding the need for Ontario collection facilities such as the ones they propose. Furthermore, Canadian Blood Services (CBS) asserted, in the limited Health Canada consultation in April that supply from current international suppliers was sufficient to meet current and anticipated need, suggesting that current practice is adequate. CBS also noted that the annual capacity of 600,000 to 700,000 litres required to maintain a Canadian processing facility cost-effectively was not likely to be met in the near future.

Should your government be considering changing policy on this issue, we look forward to an opportunity for consultation on this issue. ♦

# MATTHEWS' REPLY ON PAID PLASMA DONORS

*On August 19, 2013, Minister Matthews replied to Guyatt's letter, indicating that she would be consulting with stakeholders before any permits or licences are issued.*

Thank you for your email on behalf of the Medical Reform Group Steering Committee sharing your concerns about maintaining the supply of blood from volunteer donations.

I appreciate and share your concerns regarding the issue of paid donors. I strongly believe that before Canada considers allowing paid-donor blood plasma clinics to proliferate throughout the country, we first need to develop a better understanding of the impact that this development would have on our voluntary blood products donor system.

As you may know, our blood supply is managed at the national level by CBS, which was founded on the key principle that "voluntary donations should be maintained and protected." The federal government played a substantive role in the transition from the Canadian Red Cross Society to CBS as a single operator of a national blood supply system (except Quebec, which is served by Hema-Quebec), and did so in response to the Government of Canada's Commission of Inquiry on the Blood System in Canada led by Justice Horace Krever. The final report recommended that the Canadian blood supply system be governed by five basic principles, one of which is that "donors of blood and plasma" should not be paid for their donations, except in rare circumstances."

I believe the integrity of our voluntary non-remunerated blood system must not be compromised and that we need to work together with our federal, provincial and territorial colleagues to find the best way forward.

CBS collects blood and blood plasma only from volunteer dona-

*(continued on page 17)*

# MATTHEWS' REPLY (continued)

tions. I'm confident that Canadians will continue to voluntarily donate blood, plasma and platelets for altruistic reasons, rather than financial incentives.

Any proposed plasma collection clinic in Ontario would need an approval from both federal and provincial levels of government to operate. The safety and quality of blood plasma collected in Canada is the responsibility of Health Canada under the authority of the Food and Drug Act. Ontario also licenses and regulates laboratories under the authority of the Laboratory and Specimen Cof11 action Centre Licensing Act. I asked Health Canada to refrain from granting approval of any new paid-donor blood plasma clinics until there has been an open consultation with provincial !health regulators, care providers, CBS and Canadians.

Health Canada held a round table discussion on the topic of Payment of Plasma Donors in Canada, for the purpose of informing next steps by Health Canada. The discussion brought together stakeholders from patient advocacy groups, academia, provincial/territorial governments, CBS and Hema-Quebec. Health Canada posted a summary of these discussions, including a backgrounder paper on its web site and up to July 26, 2013, Canadians had the opportunity to express their views on the summary report of the round table discussion. You may wish to visit the Health Canada web site at: http://www.hc-sc.gc.ca/dhp-mps/consultation/biolog/plasma-consult-eng.php

Now that Health Canada's consultations have been closed, my ministry will be reviewing its options before determining next steps in Ontario.

The integrity of our blood donor system must not be compromised. We need to work together to find the best way forward. Blood donation saves lives. That's why I'll continue to encourage people to donate blood voluntarily.

I appreciate your taking the time to write to me and share your comments and concerns about this important issue.♦

# MRG CALLS ON PREMIER TO COMMIT TO FAIRNESS AND INCLUSIVENESS FOR SOCIAL ASSISTANCE RECIPIENTS IN 2013 BUDGET

The Medical Reform Group, a group of doctors committed to universal high quality health care for all Canadians acknowledges the commitment of Premier Wynne to build a brighter future for all the people of Ontario, and called today for her to demonstrate the principles of fairness and inclusiveness in the budget expected on Thursday, May 2nd.

"For far too long, government has focused on investing to remedy the results of poverty instead of addressing the prevention issue head on," noted MRG spokesperson Dr. Ritika Goel. "We think it is time to shift the debate and make a direct commitment to social assistance recipients in Ontario. We are sure an immediate down payment of $100 added to the base social assistance rate of $606 monthly, and a commitment to adjust rates annually for inflation would have positive results for us all."

Her colleague, Dr. Ahmed Bayoumi added, "We are not only calling for expenditures with the down payment proposal. The provincial government can also provide leadership, by increasing the legislated minimum wage, and beginning to implement some of the excellent recommendations of its Ontario Social Assistance Reform Commission."

The current Ontario Works benefit for a single person is $606 per month. Minimum wages have been frozen at $10.25 since 2010, in spite of McGuinty's 2008 promise of gradual increases to reach $11.50 by 2012.

The Ontario Child Benefit, originally touted as a cornerstone of the province's child poverty reduction strategy, has stalled since 2011 at $1,100 per child, with the result that child poverty rates are again increasing. According to former Children's Minister Hon. Laurel Broten, the partial implementation of the Ontario Child Benefit between 2007 and 2011 lifted some 80,000 Ontario children out of poverty.♦

*Released by the Medical Reform Group May 1, 2013*

# DOCTORS APPLAUD CITY OF TORONTO'S SUPPORT FOR HEALTH CARE ACCESS FOR ALL

In a strongly worded motion adopted yesterday, the City of Toronto is the first in Canada to support access to healthcare services to all people in Ontario, irrespective of immigration status. Members of the Medical Reform Group (MRG), an advocacy group of progressive doctors, see patients every day that are unable to access essential healthcare services, simply because they do not have an OHIP card. As such, we stand proudly with the City of Toronto in calling for impartial medical care offered to uninsured residents.

Recognizing that the health of many Torontonians is deteriorating without access to healthcare, Canada's largest city made precedence by officially calling on higher governments to fill the holes in healthcare coverage.

"All too often, I see first hand the devastating impact that lack of health insurance has on my patients," said MRG spokesperson Dr. Reed Siemieniuk. "I watched a patient suffer for weeks with a severe infection because he did not have sufficient coverage for the usual therapy. I'm proud to live in a city that recognizes the importance of caring for our most vulnerable in times of need."

Toronto's City Council urged Ontario to increase funding to community health centres and other agencies that already provide services to the uninsured, but the hope is that the broader system will better learn how to provide such care for all. The City also called on the federal government to rescind cuts to the Interim Federal Health Program and on the provincial government to remove the 3-month waiting period for new immigrants to Ontario.

"As Canada's largest city, Toronto is showing critical leadership by demanding that our society takes care of its most vulnerable," said another MRG spokesperson Dr. Ritika Goel. "It is unconscionable that we would put immigration status before need in this country when health is at risk. People have died as a result of inequitable access in this country. This has to stop."

The full motion can be found at: http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2013.HL21.5"♦

*Released by the Medical Reform Group May 10, 2013*

# ONTARIO MINISTER OF HEALTH RESPONDS TO MRG ON HOME CARE FEES

*On June 20, 2013, we got this reply from Minister Matthews to our letter sent April 3th, 2013 (see last issue of MEDICAL REFORM). We'll be continuing to press for an answer.*

Thank you for your letter regarding income/means-testing for drugs and home care services.

I want you to know that Ontario remains committed to a fairer drug system for seniors. As outlined in the 2012 Ontario budget, we will be asking the five per cent of seniors with the highest incomes to pay more of their own prescription drug costs — so the province can invest in more home care and supports for all seniors. This change will affect single seniors with incomes over $100,000 and senior couples with a combined income over $160,000. Drug costs for seniors below these net income levels would remain the same. I'd like to note that this reform has the support of CARP because savings from these changes will help to achieve more extensive health coverage for Ontario's seniors.

Regarding home care and community support, I'd like to be perfectly clear that the government has no plans to require income-testing for these services at this time. This was a recommendation made by the lead expert of our Seniors Care Strategy, Dr. Samir Sinha, in his report "Living Longer, Living Well."

My ministry continues to review Dr. Samir Sinha's report, and we hope to be able to take action on a number of his recommendations to provide seniors with more options to stay at home longer and receive care in the community. Our goal is to find opportunities to improve the system and provide seniors with the services they need, when they need them.

Our Seniors Care Strategy is committed to helping older Ontarians to receive timely access to care in the most appropriate place. I know that many of our province's seniors want to stay at home, closer to their families, for longer. This is why we're making significant investments in the community sector.

I look forward to continuing to work with Dr. Sinha as my ministry implements our Seniors Care Strategy. I'm confident that it won't be long before Ontarians see more positive developments in the delivery of home and community care services to our seniors.

Thank you again for writing to share your concerns.♦

# NO JETS TORONTO

Members may have heard about the West Jet proposal to expand the Toronto Island airport to accommodate jets and a significant increase in traffic at that loation. MRG Members Miriam Garfinkle and Susan Woolhouse wrote the Toronto Mayor, City Councillors, the City's Water Secretariat and Medical Officer of Health Dr. David McKeown on August 3rd to lobby against the expansion of the Billy Bishop Airport on the grounds that the health effects of exposure to jet fuel and byproducts and excessive noise pollution to well-established communities, including local schools and day care centres.

The council has agreed to a short consultation and study period which will include a health impact assessment from the Toronto Board of Health. The City has launched an online survey to seek feedback with a very short deadline of October 11th, 2013. An information booklet, background documents and other studies/reports are posted online at www.toronto.ca/bbtca_review. Please be in touch with Janet Maher at medicalreform@sympatico.ca if you would like further information as it becomes available.♦

# 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 _____
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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:
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# INJURED WORKERS ISSUES

*Ted Haines and Janet Maher*

The MRG has worked for many years with Injured Workers' Consultants (IWC), the Ontario Community Legal Aid Clinic which focuses on representing injured workers as they seek care and support on workers' compensation issues and we recently attended one of their periodic meetings (May 16th, 2013) with physicians, including several psychiatrists, to review experience with the Workplace Safety and Insurance Board (WSIB).

The clinic had been hearing increasing complaints from physicians who do a lot of WSIB-related work with clients of

- Refusal to pay for some medical reports and treatments;
- Disregard for treating physicians' medical opinions in favour of their own internal advisers; and
- Subjection of some injured workers to video surveillance and other practices which have a negative effect on their mental health, and
- Increasing use of 'specialty' clinics whose diagnoses are preferred to those of family/attending physicians.

It was noted that stress claims have always been difficult to deal with to the satisfaction of the patient and her/his family doctor, as psychiatric diagnoses have always relied on less apparently 'objective' or 'scientific' criteria. A successful case, therefore, relies much more on the facts of a case reported in medical reports than for those involving physical injuries. It was also noted that in some cases, treatments which had once been routine for WSIB clients are no longer covered and some clients have been forced to apply for welfare to get access to a broader range of therapies.

The consensus of the meeting was that a new case management model, where the WSIB case managers are not physicians but essentially clerical workers appears to be resulting in the initial denial of claims which subsequently are awarded compensation. Those advocates at the meeting noted that they have been relatively successful in individual advocacy for clients referred to them, but they have concern that clients who do not have access to the legal clinic or expert medical advice by physicians familiar with WSIB processes abandon their claims prematurely. This would account for their perception of increasing numbers of injured workers relegated to the Ontario Disability Support Program (ODSP) or municipal welfare.

In discussion, it was agreed that there may be some merit to a dedicated campaign which would explore one or more of the following in the next year:

- Raise awareness in the medical community and the public at large about the case management system which may be infringing on the physician patient relationship by countermanding the advice of the family doctor/attending physician; and/or
- Collaboration of physician and legal advocates on an educational campaign which alerted family physicians to the need for care in the preparation of medical reports for WSIB-related cases.

MRG representatives spoke to the success of Health Providers Against Poverty in raising the profile of poverty issues for low income Ontarians by designing and publishing clinical guides and checklists to assist their physician colleagues in preparing for successful claims.♦

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