



# Import



## A WEEKLY REVIEW OF DEVELOPMENTS IN HEALTH AND HUMAN SERVICES

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*Welcome to this edition of Import. In it you will find summaries of new and interesting issues and developments in health and human services, as well as "In My Humble Opinion," a short analytical article by an Agora Group affiliate. Please feel free to visit The Agora Group's web site, which can be accessed by pressing the "our affiliates" button on the Consultant Network web site: [consultant-network.ca](http://consultant-network.ca).*

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### **ONTARIO: CAMH MAY MOVE TO SINGLE SITE**

According to a July 10 *Toronto Star* article, Ontario's Centre for Addiction and Mental Health (CAMH) may relocate its four major Toronto-based facilities to a single site using a public-private partnership (P3) as a way to create the mega-facility.

According to documents obtained by the *Star*, CAMH (which was created several years ago from the merger of the Queen Street Mental Health Centre, the Clarke Institute of Psychiatry, the Addiction Research Foundation and the Donwoods addiction treatment facility) may concentrate its services in a new complex on the Queen Street site which was originally the location of Ontario's first purpose-designed mental hospital (the "Upper Canada Asylum for Lunatic and Insane Persons").

Under the "P3" model, the new facility would be built by the private sector and leased to CAMH.

CAMH officials say no decision has yet been made to create the mega-facility or to use the P3 approach, but say both ideas are under consideration.



New hospital physical plants based on the P3 model are under development in Brampton and Ottawa, and may be developed in Markham and Peterborough as well.

The P3 model has been a contentious issue in Ontario, with opponents claiming it is the first step toward privatization of health services. Supporters, however, claim P3 arrangements allow hospitals to maintain full control of their clinical programs, while cross-loading the up-front costs of capital construction to the private sector.

The Ontario government and the Ontario Hospital Association have both voiced support for P3 developments.

### **OTTAWA DETOX CENTRE: HOSPITAL THROWS IN THE TOWEL**

In response to a decade of what it considers to be under-funding of addiction services, SCO Health Services of Ottawa (a multi-site hospital operated by the Sisters of Charity) has announced it will reduce beds in its Ottawa Withdrawal Management (detox) Centre from 26 to 20, and it intends to cease operating the centre as soon as an alternative operator can be found (under Ontario law, detox centres must be operated by hospitals).

Commenting on the issue in a media release, the Alcohol and Drug Recovery Association of Ontario (ADRAO) said:

*"Addiction programs have only received a mere 2% funding increase in the past 10 years. This financial situation is not just impacting the Ottawa program, but all types of addiction programs across the province. This is not the only withdrawal management centre that has faced the possibility of reducing or terminating its services. A number of Ontario programs reduced or temporarily closed their services last year in order to deal with deficits, and the same will happen again this year".*

ADRAO has requested a meeting with Ontario's Premier and Minister of Health to discuss the funding crunch.

### **ONTARIO INCREASES FUNDS FOR PHARMACY SERVICES**

On July 4 Ontario announced \$41.5 million in enhanced funding over the next four years for pharmaceutical services. The funding includes a 1% increase in dispensing fees pharmacists charge for filling prescriptions for Ontario Drug Benefit Program recipients (ODB covers medication costs for seniors and people on social assistance). The increase is meant to allow for technology upgrades. The government will also provide up to \$5 million per year for medication management demonstration projects focusing on complex medication regimens, physicians consulting with pharmacists about drug choices for their patients, and pharmacists working with patients and physicians to promote compliance when taking medications.

### **NOVA SCOTIA TO FUND ACCESS PROJECTS FOR PEOPLE WITH MENTAL DISABILITIES**

On July 10 Nova Scotia released a call for proposals for projects to help people with mental disabilities access Nova Scotia's justice system and other advocacy services.

The Nova Scotia Human Rights Commission, in co-operation with the Disabled Persons Commission, has made \$90,000 in funding available over three years for these projects. The first award was made in 2002. Mental health associations and consumer advocacy groups are eligible to apply for the grants, and guidelines for the grants are found at [http://www.gov.ns.ca/humanrights/publications/guidlines\\_03\\_04.pdf](http://www.gov.ns.ca/humanrights/publications/guidlines_03_04.pdf).



## **NATIONAL VOLUNTARY ORGANIZATIONS TO JOIN FORCES**

In a move to create a stronger, more unified voice for the voluntary charitable sector in Canada, two national organizations – the Coalition of National Voluntary Organizations (NVO) and the Canadian Centre for Philanthropy (CCP) – have agreed to co-found a new organization *“to strengthen communities and advance social development through collective effort”*. While neither NVO nor CCP call it a merger, both organizations will cease to operate once the new organization is in place (likely by June 2004).

NVO is a national, non-profit, membership-based organization that represents a broad, diverse array of national voluntary organizations. NVO provides a link between the voluntary/charitable sector and government policy makers. CCP is a membership-based organization that works with charities, governments and corporations to advance the role and interests of the charitable sector for the benefit of Canadian communities.

## **HEALTH CANADA ANNOUNCES MEDICAL POT INTERIM PROVISIONS**

On July 9 Health Canada announced interim provisions to ease access to medical marijuana for people whose physicians believe they need it for medical purposes. Under the interim provisions:

- Health Canada will make marijuana seeds available to persons authorized to produce marijuana for medical purposes and who do not currently have plants at any stage of production
- Health Canada will provide a legal source and supply of dried marijuana to individuals authorized to use marijuana for medical purposes who are unable to produce it themselves or find a person who can produce on their behalf under the government's *Marihuana Medical Access Regulations*

In both instances, fees will be charged to those using the services. The marijuana seeds and product will come from Prairie Plant Systems Inc., the company currently under contract with Health Canada to produce marijuana for clinical trials.

Protesting the interim provisions, on July 9 the Canadian Medical Association issued a media release saying:

*“[Health Canada’s] Its interim policy on the provision of marijuana for medical purposes does nothing to address patient safety issues. The CMA has consistently raised concerns about the lack of evidence-based decisions to support the Medical Marijuana Access Regulations. Our unease over use of medical marijuana has been ignored in this new policy. Physicians should not be the gatekeeper for a substance for which we do not have adequate scientific proof of safety or efficacy... Since the government has not made the case for the safety of the medical use of marijuana, the CMA strongly recommends that the physicians of Canada not participate in dispensing marijuana under existing regulations, and warns that those who do, do so at their professional and legal peril”.*

In light of the resistance of the medical profession, Health Canada's interim provisions may do little to improve access to medical marijuana. In response to the interim provisions Gregory Robinson, a Toronto physician and medical marijuana user, resigned from Health Canada's Stakeholder Advisory Committee on Medical Marijuana, saying he had lost faith in Health Minister Anne McLellan's *“ability to understand compassion for seriously and chronically ill patients”*.



## **PROVINCES, TERRITORIES TO CREATE “COUNCIL OF THE FEDERATION”**

The recent meeting of Premiers of Canada's provinces and territories wrapped up last week with unanimous agreement to create a Council of the Federation, comprising the premiers of all provinces and territories. The council will put forward to the federal government issues of concern to provinces and territories. Some premiers were initially lukewarm to the idea, but all came on side by the end of the conference, in part because it had been proposed by Quebec Premier Jean Charest. Fellow premiers did not want to reject the first Canada-wide proposal put forward by a Quebec premier to his colleagues in several decades. The premiers say the council will resemble a permanent think-tank and clearing house, with a small staff to help them research, debate and communicate common provincial goals on health care, inter-provincial trade, mobility rights and other issues. The mandate and structure of the Council will be established at a First Ministers' meeting in October.

Creation of the Council of the Federation is the first of five elements in what the premiers called *“a plan to revitalize the Canadian Federation and build a new era of constructive and cooperative federalism for Canadians”*. Other elements in the plan are:

- annual First Ministers' meetings (including the Prime Minister)
- a demand for provincial/territorial consultation on federal appointments
- a proposal for greater devolution of powers to the territories
- establishment of federal provincial territorial protocols of conduct (an idea proposed initially by Newfoundland and Labrador and subsequently championed by all Atlantic premiers).

Citing health care as their number one priority, the premiers also called on Ottawa to increase health funding by \$3 billion in 2004/05 and 1% per year after that until the federal share of funding is 25% of provincial/territorial health and social expenditures. Premiers also called on the federal government to honour a previous pledge to transfer over \$2 billion in surplus revenues to the provinces and territories this year. All premiers also supported Ontario's demand for \$850 million to cover the costs of SARS rather than the \$250 million offered by Ottawa.

The premiers also avoided a split on the idea of creating a national Health Council – a key recommendation of the Romanow Commission report – by saying instead that more work needs to be done on defining its mandate and affordability, and that they intend to discuss the idea of the Health Council with the next Prime Minister. The premiers of Alberta, Quebec and Ontario have all expressed reservations about the Health Council, stating concerns that it might become another level of bureaucracy, dominated by federal civil servants. On July 10, Alberta issued a media release saying *“Alberta is not participating in the National Health Council as currently proposed by the federal government”*.



Anticipating the premiers' foot-dragging on the Health Council, on June 10 the Canadian Medical Association issued a media release saying:

*"We are extremely disappointed that some premiers are holding this pivotal initiative hostage and are kicking it around to score short-term political points... Since the Council is the first step in the implementation of the First Ministers' Health Accord, this does not bode well for the other initiatives. The CMA remains hopeful that governments will 'rise above political interests' that have so far delayed the creation of the Council and heed the calls of Canadians for an effective Council, one the CMA says must be legitimate, independent, transparent, credible and permanent".*

### **WHO JOURNAL PROFILES CANADIAN IMPACT ASSESSMENT**

The World Health Organization's June 2003 *Bulletin* (a journal of international public health) contains an article profiling Canada's integrated "environmental impact assessment" (EIA) for new industrial developments, using the BPH diamond mine in the Northwest Territories as an example of how to evaluate determinants of health. The authors of the article *Integrated environmental impact assessment: a Canadian example* draw these lessons from the Canadian experience:

*"EIA must involve more than identifying, assessing and mitigating the negative environmental impacts. It must also identify and mitigate perceived concerns and enhance, where possible, the positive aspects of a project. Environmental, health and social consequences of development activities contribute valuable information to each other and draw extensively on comparable and closely interrelated data. The health of the environment is clearly an important aspect of a community's health, but it is not the only determinant. How individuals, families and communities are affected by development, and the social consequences of that development, provide critical information for health professionals. Similarly, knowledge of the impacts on the quality of life and health of individuals, families and communities is vital to social scientists."*

The WHO article is found as a 5 page PDF file at <http://www.who.int/bulletin/volumes/81/6/en/kwiatkowski.pdf>.

### **UK AND FRANCE: BUYING MEMORIES**

As the body count of US service personnel and Iraqi civilians clicks inhumanly forward in Iraq – and as 3,600 Canadian soldiers prepare to put themselves in harm's way in the almost forgotten plains, valleys and cities of Afghanistan – it is fitting perhaps to remember earlier, even more savage conflicts, if only to recall that we have not yet extinguished the flames of war, and that the flames can kill millions.

This came to mind as a result of a recent announcement by the UK government that it has awarded funds to the Somme Association to buy Thiepval Wood, a forested area in France where thousands of British and South African soldiers died in the months-long Battle of the Somme in 1916.

The forest is adjacent to the Thiepval Monument on which are written the names of 72,000 British and South African officers and men who died at the Somme and whose bodies were never found. It is impossible to give a face or human dimension to so many men – but one face out of these thousands is Lt. Thomas Michael Kettle, 9th Royal Dublin Fusiliers, a Dublin nationalist who joined the British Army to fight *"not for England, but for small nations."* Kettle died on the Somme at the age of 36 in September 1916. He had been a university



professor and Member of Parliament for East Tyrone. Prior to his death Kettle wrote poems about his ordeal as a soldier, including *To My Daughter Betty*, *The Gift of God*, in which he pointed out that soldiers seldom fight or die for the abstracts of king or country, but die nevertheless for principles:

*"So here while the mad guns curse overhead,  
And tired men sigh with mud for couch and floor,  
Know that we fools, know with the foolish dead,  
Died not for flag, nor King, nor Emperor,  
But for a dream, born in a herdsman's shed,  
And for the secret Scripture of the poor."*

The Somme accounted for over one million casualties among all armies engaged in the battle, and gained an advance of a paltry 12 kilometres at most for the French and British armies (for the statisticians among us, this was 93 casualties for each metre of ground).

As well, amid our annual celebration of Canada Day, it does us well to remember that Newfoundlanders still recognize July 1 as a day of mourning in remembrance of a staggering loss of Newfoundland's men at Beaumont Hamel on July 1 1916, the opening day of the Battle of the Somme. On that day, 801 members of the First Newfoundland Regiment left their trenches to cross No Man's Land. The next day, only 68 of them were alive and well enough to answer roll call. In the dry tally of which history is so fond, 233 Newfoundlanders were killed or died of wounds at Beaumont Hamel, 386 were wounded, and 91 were listed as missing. Every officer who went forward in the Newfoundland attack was either killed or wounded.

And we have a way to go yet, before we agree on a better way than war to fight for *"the secret Scripture of the poor"*.

### **CANADA SIGNS TOBACCO CONTROL TREATY**

On June 15 Canada signed the Framework Convention on Tobacco Control (FCTC), the first ever global public health treaty, at a ceremony held at the United Nations in New York. More than 40 other nations have already signed the Convention, which deals with a number of tobacco-related issues including packaging and labeling, advertising and public education programs. The Convention is available as a 26 page PDF file at [http://www.who.int/gb/EB\\_WHA/PDF/WHA56/ea56r1.pdf](http://www.who.int/gb/EB_WHA/PDF/WHA56/ea56r1.pdf).

The FCTC was adopted by member countries of the World Health Organization at the World Health Assembly on May 21 2003, following almost three years of negotiations. The Convention will come into force ninety days following ratification of the Convention by 40 countries.

### **AUSTRALIA: FIRES OF 2002 BURNED 10% OF COUNTRY**

In what will likely add fuel to debates between forest industries and conservationists, Australia's National Association of Forest Industries blamed last summer's devastating bush fires on conservation policies that led to an increase on forest floors of "fuel" – dried leaves, twigs and other flammable debris. The Association, testifying before a committee of the Australian Parliament investigating the fires, said almost 10% of the country was blackened by the fires that were abetted by severe drought. Smoke from the fires was equivalent to all Australian vehicle emissions for a 12-month period and carbon dioxide emissions from the fires



amounted to 120-130 megatonnes – equivalent to roughly 20% of Australia's total annual carbon dioxide output, according to the Association. Said the Association's executive director Kate Carnell, *"This wasn't just another bushfire. This was the worst environmental disaster in the written history of this nation"*.

### **OUR NEXT DOOR NEIGHBOUR IS EVERYONE: FARMERS HELPING FARMERS**

For almost a quarter century a Prince Edward Island organization, Farmers Helping Farmers, has been working with farmers in Africa to help them improve their agriculture. The work of Farmers Helping Farmers received a major boost last week thanks to a grant from the Canadian International Development Agency (CIDA) to help fund two of the organization's chief African projects:

- The **Muchui Women's Group** in Kenya, which received 60 water tanks thanks to PEI donations, will start tree seedling nurseries using a small portion of the water from their tanks. The trees will be sold for cash needed by Muchui's farm families, in addition to providing food, lumber, shelter and firewood. Farmers Helping Farmers will assist them, using CIDA funds, with training and start-up costs associated with the tree seedlings.
- Kenya's **Wakulima Self-Help Group Dairy** consists of 3,500 farmers with one or two cows each. The farmers work cooperatively to ship their milk to a cooling plant funded by Farmers Helping Farmers. The new CIDA grant will help solve problems identified by the Wakulima farmers as crucial – access to credit, veterinary services, better quality control for their milk and assistance in product development. CIDA funds will be used to set up a credit system for the farmers, with an interest rate of 10%. As well, for the next three years three final-year students from the Atlantic Veterinary College (AVC) will visit Kenya for three weeks to diagnose problems in Wakulima's dairy cattle and give African dairy farmers technical assistance on herd health management, with help from a supervisor from the AVC's Department of Health Management.

Such small-scale farmer-to-farmer initiatives stand in stark contrast to policies for African agriculture touted by US President George W. Bush during his recent African tour. Bush has been promoting biotechnology – particularly genetically modified foods – as a solution to Africa's food supply problem, but a July 11 *New York Times* editorial by Charles Benbrook, an agricultural consultant, puts the Bush proposals in a different light:

*"The first generation of genetically modified food crops – corn and soybean seeds – were created to make pest management simpler on America's large, mechanized farms. The technologies would be far less effective on African farms, which are small and diversified and rely largely on human labor. These technologies don't make economic sense. In the United States, most farmers planting genetically modified seeds break even – the increase in seed costs, approximately 35%, is covered by reductions in pesticide expenses or marginally higher yields. In stable, well-irrigated environments, these crops enable individual farmers to cultivate more land. In Africa, however, these benefits can be burdens. For cash-poor farmers, the cost of genetically modified seed would be prohibitive. Moreover, genetically modified crops need near-perfect growing conditions. In dry areas, they require irrigation systems and the water to run them. They also need to be managed with special care. For example, crops are engineered to work with specific herbicides; the wrong herbicide can ruin an entire crop. In Africa, where pesticides are often misbranded, sold in unmarked containers or handled by people who cannot read, this can be a problem. Governments will also bear increased responsibilities and costs in*



*carrying out and assessing health and environmental safety testing for these crops, a task few African nations are able to take on”.*

The Bush administration has filed a complaint with the World Trade Organization against the European Union for its moratorium against the approval of genetically modified crops, claiming European policies have turned some African nations against biotechnology and have undermined US efforts to help Africa.

### **INDIA: COOKING STOVES KILLING WOMEN**

An opinion piece in the July 10 newsletter of India's Centre for Science and Environment (CSE) profiles the work of Kirk Smith, former professor at the East-West Centre in Hawaii, concerning the health of women exposed to smoke from cooking stoves in India. Says the CSE article:

*“Monitoring kitchen smoke in Gujarat villages had revealed that women were exposed to total suspended particulates of about 7,000 microgrammes per cubic metre ( $\mu\text{g}/\text{cum}$ ) in each cooking period (compare this to annual standards for outdoor air at 140  $\mu\text{g}/\text{cum}$ ). Worse, how the exposure to benzo(a)pyrene – the carcinogen in cigarette smoke and found in biomass smoke – was equivalent to smoking 10 packets of cigarettes in a day.... What also became clear is that women are exposed to more toxic tiny particulates, in a cooking cycle, than the inhabitants of the most polluted city in the world – a 24-hour concentration measured inside homes can be above 2,000  $\mu\text{g}/\text{cum}$ . Compare this to the standard for ambient air pollution: 60  $\mu\text{g}/\text{cum}$  daily average.... Today, the World Health Organisation estimates there are over 1.6 million premature deaths each year from cookstove pollution. Some 400,000 to 550,000 women and under-five children die prematurely each year in India because of this deadly smoke.... In addition, [Smith] estimates that lost health life years (calculated as disability-adjusted life years or DALYs) could range from 12-17 million each year. Sick days could cross over 2 billion each year. The burden of disease from cookstoves comes right after dirty water and lack of sanitation (which contribute over 10% of the disease burden and malnutrition, over 22% of the disease burden in India). In other words, by providing access to clean water, sanitation, food and ventilated homes, we could wipe out over half the disease and premature deaths in the country”.*

### **WORLD BANK, EUROPE TO TACKLE ROMA EXCLUSION**

With assistance from the World Bank, Europe's nations will hold a conference in late July to address issues related to Europe's sizable Roma (gypsy) population. The issue has heated up because a number of eastern European nations have applied for membership in the European Union, which requires member nations to put in place policies to address systemic problems of Roma exclusion and marginalization.

In preparation for the conference the World Bank has issued *Roma in an Expanding Europe: Breaking the Poverty Cycle*. The report notes that 7 to 9 million Roma live in Europe – the equivalent of the population of Sweden or Austria. The figures are imprecise since some Roma do not admit to Roma ancestry during national censuses for fear of discrimination. While most Roma live in Romania, Hungary, Bulgaria, the Slovak Republic, Turkey, and Serbia and Montenegro, more than 1.6 million live in western Europe (630,000 in Spain alone).



Roma often live in conditions of poverty, unemployment, ill health and social exclusion. The report posits the need for policy action to better the lives of Europe's Roma:

*“Political liberalization following the collapse of the iron curtain in 1989 allowed for increased international and domestic awareness of the situation of Roma, including emerging human rights violations and humanitarian concerns related to deteriorating socioeconomic conditions. National governments have a large stake in the welfare of Roma, for human rights and social justice concerns, but also for reasons of growth and competitiveness. In countries where Roma constitute a large and growing share of the working age population, increasing marginalization of Roma in poverty and long-term unemployment threatens economic stability and social cohesion. Understanding the nature and determinants of Roma poverty, and taking policy action are thus important priorities.... What is distinctive about Roma in Europe is that they have endured centuries of exclusionary and assimilationist policies without being absorbed into majority societies. They remain stateless and have founded no movement for statehood because they lack a historic homeland”.*

The report points to some of the reasons for the plight of Europe's Roma:

*“Roma poverty is rooted in their unfavorable starting point at the outset of the transition from planned to market economies. Low education levels and over-representation among low-skilled jobs led to disadvantages on the labor market, which are compounded by discrimination and low expectations of employers. Roma have thus had more difficulty re-entering the job market than other groups and have become caught in a vicious circle of impoverishment. Additional barriers include a lack of access to credit and clear property ownership. These factors, combined with an over-dependence on welfare, create a poverty trap that precludes many Roma from improving their living conditions or starting their own businesses. Persistent disadvantages in education, including low school attendance and overrepresentation in ‘special schools’ intended for physically and mentally disabled children, make it highly probable that without policy interventions the next generation of Roma will remain in poverty. Moreover, very few Roma are active in local or national politics, which mutes their political voice.... Roma often have poor access to labor markets because of low education levels, geographic isolation, and discrimination. Low education levels result from constraints on both the supply and demand side. Roma often face discrimination in school and feel that schools ignore Roma culture and language. In addition, Roma sometimes lack sufficient food or clothing to support school attendance. Thus, attitudes, experiences, and social conditions conspire to reduce Roma education levels and labor market performance. Because of these inter-connected roots, one cannot adequately address Roma poverty by focusing on a single aspect. Rather, a comprehensive approach is needed”.*

The report says diversity within Roma communities makes it unlikely that a single set of uniform policies will work for all. It cites a recent study of nine Roma communities in Romania, for instance, in which *“each of the nine communities consists of different combinations of Roma sub-groups, with different languages, religions, and occupations”.*

The report cites Hungary as a nation that moved quickly to address Roma disadvantage:

*“Hungary passed a Minorities Act in 1993 that granted considerable cultural, educational, and linguistic rights to Hungary's thirteen recognized minorities, including Roma. This Act created a*



*system of national and local minority self-governments that let minorities initiate social, educational, and development projects. Approximately half of these are Roma self-governments. Hungary has also established a national Office for National and Ethnic Minorities, an independent Minorities Ombudsman to oversee minority rights and protections, and a Roma Office under the Office of the Prime Minister to coordinate Roma policy across the government. Together, these offices enable Hungary to comply with EU norms, in part through the implementation of a 'medium-term package' of measures aimed towards social inclusion of Roma".*

A 30 page executive summary of the World Bank report is at [http://lnweb18.worldbank.org/eca/ecshd.nsf/ECADocByUnid/EDF5EC59184222F8C1256D4F0053DA41/\\$FILE/Executive%20%20Summary.pdf](http://lnweb18.worldbank.org/eca/ecshd.nsf/ECADocByUnid/EDF5EC59184222F8C1256D4F0053DA41/$FILE/Executive%20%20Summary.pdf).

*(Editor's note: Canada would be well advised to monitor Europe's struggle to establish rights and opportunities for its Roma population, in part because it may generate ideas that prod Canada toward greater self-determination and inclusion for Canada's Aboriginal citizens).*

### **OUR READERS SAY.... "SUITCASES AND BIG DREAMS"**

In my cover note to the last edition of *Import*, I said I was one of the many children who arrived at Pier 21 in Halifax to begin my life in Canada. A reader responded by pointing to a new web site that is meant to record the experiences of ordinary Canadians:

*"I would invite you and others like you who arrived in Halifax as my parents did too, to check out a friend of mine's web site and tell your story of why you choose Canada. Donna Messer will be writing a book on what is shared as a part of her quest to promote Canada. The web site is [www.wechoosecanada.ca](http://www.wechoosecanada.ca). It has just been launched a few days ago and is being well received".*

The "We Choose Canada" web site is part of a larger project created by Donna Messer and Debbie Trenholm to showcase why Canadians love their country. The web site allows Canadians to record their own experiences in coming to or living in Canada, and it also aims at recruiting volunteers to act as "Canadian Ambassadors" by interviewing people in their own neighbourhoods about why Canada matters to them. Debbie and Donna became the first two Ambassadors on July 1 in Ontario, and hope to expand the Ambassador program to other provinces if funding allows. Among the many stories already on the web site, Nina (born in India and a resident of Kuwait before immigrating) wrote:

*"I decided to apply for immigration and finally made the move from Kuwait to Canada in 1999 with suitcases and big dreams.... I feel safe and free here. Since moving here, my life has gone through a 360 degree turnaround and I'm a whole new person. I'm doing what I love and enjoying every moment of it. Thank you Canada for making my dreams come true!!"*

In response to last issue's editorial in which I suggested funds might be diverted to infectious disease control from other important areas of public health, a reader wrote:

*"Your comments on what governments will do to fund the next public health crisis are well taken. You can bet that the litany to be heard in response to any request for funding in the health area will be "we spent it on SARS".*



## **IN MY HUMBLE OPINION: TWO MODEST PROPOSALS**

As I sip cool drinks on hot summer days in my back yard, my mind occasionally turns from an endless battle against weeds and earwigs towards grander ideas to make our health system better. I take a leaf from the essayist Jonathan Swift by suggesting two modest proposals that will, undoubtedly, improve things. No, don't thank me. You would expect nothing less from a full-service consultant.

### ***The First Proposal: A Regional Health Parking Strategy for Ontario***

You may have noticed that almost all health facilities in Ontario, from the grandest hospital to the humblest clinic, have parking spaces for their clients. Hospitals generally charge for parking but most other health facilities do not charge, and the cost of parking areas is often buried within their rental agreements – a cost ultimately shouldered by the harried taxpayers of Ontario who fund the operating costs of these agencies.

Enough I say. It is time to rationalize the parking system. I propose that in each of Ontario's health regions, a single Amalgamated Parking Centre should be created, to serve all health services in the region. In Northeastern Ontario, for instance, a massive parking lot near, say, Wawa (where land downwind from the smelter is cheap) could serve clients from as far afield as Manitouwadge and Moosonee. No other health-related parking lots would be allowed anywhere in the region, thereby creating a massive economy of scale.

But wait a moment, you might say – how is a frail client who needs service in Kapuskasing supposed to get from the parking lot in Wawa to her medical clinic in Kapuskasing? The answer – it should be of no concern to government. Ontario does not currently pay for the cost of clients to travel fifty metres from their hospital parking lot to the hospital's front door, and it should not be responsible for similar costs in future either. Fifty metres or five hundred kilometres – the principle is the same. In short, my idea shows remarkable consistency between current policy and future policy.

Revenues from parking fees in each Regional Parking Centre would be split among health agencies (after allocation of 90% of the fees to the Government of Ontario as repayment for its wisdom in creating such a streamlined system in the first place).

### ***The Second Proposal: Tattoo Therapy***

**Fact:** tattoos are no longer the preserve of bikers and sailors. My accountant has a tattoo. My daughter has three of them. I have no doubt the Presbyterian minister at the end of my street has one too. Alas, I do not yet have one, although I like the idea of having "The Agora Group – Give Me Liberty or Give Me Death" tattooed on my forearm.

**Fact:** each day in Ontario, thousands of people undergo surgical procedures. Most of them are under anaesthetic while the procedures are performed.

What a golden opportunity to offer pain-free tattooing at the same time! While a skilled surgical team is working on one end of the patient, a skilled team of tattooiatricans can be working at the other end – for a fee (most of which would of course go to the Government of Ontario as repayment for its wisdom in introducing such a brilliant example of medical graphics in the first place).

Your average tattooist/tattooiatrician is a fellow named Biff or Mongo, working on the front lines of private enterprise. My proposal is a great opportunity to let the "little folks" share in the benefits of Public-Private



Partnerships so strongly espoused by our current government. And I fully expect the Ontario Hospital Association to jump on this ink-stained bandwagon right away.

Keep in mind, though, that the paramount reason for such an innovation would be the Pursuit of the Public Good. Patients could be given a discount on their tattoo costs, for instance, if they agree to have the phone number of their local Family Health Network inked onto the prominently visible body part of their choice, and their complete medical records could be transcribed onto less visible body parts (thereby preserving patient confidentiality) along with the usual hearts, snakes, butterflies and tributes to Mom and Country.

The possibilities are endless in this great land of ours!

John Butler, The Agora Group

### **FROM THE QUOTES VAULT**

*"There are two things you do not want to see being made – sausage, and legislation."*

saying attributed to German Chancellor Otto von Bismark (1815-1898)