



Import



A WEEKLY REVIEW OF DEVELOPMENTS IN HEALTH AND HUMAN SERVICES

Published by The Agora Group, 12 Peter Street
Markham Ontario L3P 2A4

phone: (905) 294-9762

fax: (905) 294-8586

e-mail: agora@consultant-network.ca

web site: consultant-network.ca

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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.

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FEDS, PROVINCES MANOEUVRE OVER MEDICARE REFORM

The federal government and the provinces and territories continue to haggle over the fate of post-Romanow/Kirby health care reform in the time leading up to a meeting of the premiers and the prime minister to discuss medicare reform slated for early February, although they seem to be close to agreement on national health care priorities.

Federal Health Minister Anne McLellan set the federal stance in a January 21 speech citing nine federal government priorities (most were also priorities to the premiers):

- primary health care reform
- home care
- the better management of pharmaceuticals and drug costs
- improved access to medical/diagnostic equipment and services
- better human resources planning and management
- better use of information technology and electronic health records
- innovation and research



- improving aboriginal health
- illness prevention and health promotion.

While McLellan did not suggest a level of federal funding for the future, she called for a new accountability mechanism:

"I would like to see the creation of an advisory body comprised of representatives from the public, stakeholders, health care providers, experts and governments that can report to Canadians and their governments on the implementation of the agreement First Ministers reach, and on the state of the health care system."

McLellan's speech is at <http://www.hc-sc.gc.ca/english/media/speeches/21jan2003mine.html>.

The position of the provincial and territorial premiers, hashed out at their January 23 meeting and called the *First Ministers' Accord On Sustaining And Renewing Health Care For Canadians* is a demand for \$5.4 billion in new health care funding this fiscal year, an additional \$1.7 billion next year and a one per cent annual increase until Ottawa's share reaches 25 per cent. The premiers do not cite Romanow's key proposed new initiatives – catastrophic drug coverage and expanded home care – saying instead that *"additional funding must support the delivery of existing services and create meaningful change so that Canadians can have timely access to quality health services now and in the future."* However, the premiers identify priorities that are meant to *"build on the reforms under way across the country"*:

- primary health care (enhancing first contact services close to home)
- home and community care (providing appropriate care, including seniors' home care, and services at residential centres)
- community mental health (improving services through an appropriate mix of community based and client-centred services)
- medical diagnostic services (investing in health technologies)
- health human resources (ensuring an appropriate supply and distribution of health human resources)
- pharmaceuticals (ensuring access to appropriate, safe, high quality and cost effective prescription drugs)
- shortening waiting times for specialized medical and hospital services including modernizing health facilities
- healthy living (focusing on prevention and wellness)

Most premiers also resist any "strings attached" approach to greater federal fiscal transfers for health care, nor do they favour enhanced reporting mechanisms on expenditures of transferred federal funds, although they agree to continue publishing comparable indicators for measuring the health of Canadians. The *First Ministers Accord* arising from their meeting is at http://www.scics.gc.ca/cinfo03/850089004_e.html.

Meanwhile, on-line petitions continue to add signatures calling for governments to adopt the Romanow Commission's recommendations. The "Implement Romanow" petition sponsored by the Canadian Health Coalition now has over 35,000 on-line signatures and can be found at <http://www.petitiononline.com/romanow/petition.html>. The more recently started petition campaign by CARP (an organization representing Canadians 50 and over) has more than 2,000 signatures. CARP's petition is at <http://www.50plus.com/carp/action/petitioninfo.cfm>. The Canadian Medical Association also mounted an e-mail "100 Day Challenge" campaign for



the public to write to the Prime Minister to demand a comprehensive plan for health reform by early March (see <http://www.cma.ca/cma/menu/displayMenu.do?tab=422&skin=432&pMenuId=2&pSubMenuId=7&pageId=/staticContent/HTML/N0/I2/romanow/challenge/postcard.htm>).

On January 24 the Registered Nurses Association of Ontario (RNAO) issued its "election platform" for the Ontario election expected later this year. RNAO's strategy includes a canvass of all candidates on their positions on health care. RNAO will post responses on its web site, and will "*pay particular attention to any positions that contradict the spirit and conclusions of the Romanow report – i.e. for-profit health care.*" The platform can be accessed at RNAO's web site at <http://www.rnao.org>. Said RNAO president Adeline Falk-Rafael, "*The number one issue for nurses – and the public – in the pending election campaign is securing a strong and sustainable publicly funded and delivered health-care system. The first and fastest way to do that is to fully implement the Romanow report to bring Ontarians the reform and resources their health-care system requires.*"

As well, on January 27 the Canadian Medical Association issued *From Debate to Action*, its plan for the renewal of the health system. The plan focus on three issues:

- **accessibility:** "*In terms of accessibility, Canada's doctors recommend specific measures that will improve and ensure timely access to high quality health care, including a care guarantee, a national health human resources plan and a national health infrastructure and medical technology program. A care guarantee and a safety valve ensure that patients get the care they need, when they need it.*"
- **sustainability:** "*Canada's doctors recommend measures that will ensure the health system is funded at an appropriate level today and into the future. The key elements of these measures include moving to a 50/50 federal/provincial cost sharing of core services, a health care funding escalator and targeted core and new program funding.*"
- **accountability:** "*Canada's doctors continue to ask why patients and health care providers – those who have invested the most in the system – have the least to say in how the system operates. A Canadian Health Council, Canadian Health Transfer and Canadian Health Charter are essential to ensuring greater accountability.*"

The CMA plan is found as a 19 page PDF file at <http://www.cma.ca/staticContent/HTML/N0/I2/advocacy/news/2003/ActionPlan.pdf>.

ONTARIO ANNOUNCES COMMUNITY EMERGENCY VOLUNTEER PILOT SITES

On January 21 Ontario announced that seven communities will be pilot sites for the Community Emergency Response Volunteers Ontario (CERV Ontario) program. The program is meant to mobilize community volunteers to help their communities in emergencies such a storms, floods and major power outages. CERV is slated to become a province-wide program. The pilot communities are Barrie, Brampton, Carleton Place, Hamilton, Oliver-Paipoonge, Prescott and Timmins. Future local CERV programs will be operated through municipalities offering to be part of the program.

CERV Ontario will provide training to volunteers so they can help their neighbours to the best of their ability. Once emergency professionals are on the scene, CERV Ontario volunteers will know how to take direction from professionals on-site to provide them with the most effective support possible. Volunteers will be trained in roles



and responsibilities, basic lifesaving skills, general emergency and disaster response skills, volunteer and victim safety, the psychology of disaster, municipal emergency management programs, decision-making and teamwork, and self-help emergency functions. While membership is not restricted to retired persons, CERV Ontario is encouraging retired doctors, nurses, police officers and other emergency workers to participate as volunteers.

A media release on the pilot projects and a backgrounder on CERV Ontario are at <http://www.newswire.ca/government/ontario/english/releases/January2003/21/c1724.html>.

ONTARIO SEEKS RESOLUTION OF “TWO HATTER” ISSUE

In an odd squabble about civic engagement, the Ontario government announced on January 17 that it has appointed former superior court judge George W. Adams to conduct talks with fire services stakeholder groups and to review the use of full-time firefighters who also serve as volunteer firefighters or other emergency response personnel (called “two hatters”). The government’s media release on Adams’ appointment says:

“Because 95 per cent of Ontario communities rely on volunteer firefighters to augment or provide fire suppression services to their residents, full-time firefighters also serve in other communities as volunteer firefighters or other emergency response personnel, e.g., paramedics, while off duty. However, the international association that represents full-time firefighters prohibits that practice in its constitution. As a result, a number of ‘two-hatter’ firefighters are at risk of being expelled from their associations and losing their jobs.”

Fred LeBlanc, president of the Ontario Professional Fire Fighters Association, welcomed the appointment of Adams. LeBlanc announced he has issued a moratorium on any new charges against members who work as two-hatters during the process.

The government’s media release on the issue is at <http://www.newswire.ca/government/ontario/english/releases/January2003/17/c1027.html>.

SUDBURY VIES FOR HEALTH INNOVATION CENTRE

Sudbury Ontario has been quick off the mark in proposing that the city be one of four centres of health innovation proposed by Roy Romanow’s report. The city believes it should be considered a centre of rural health innovation, and city council has backed the bid. Councillor Doug Craig, a leader in the initiative to have Sudbury considered, sees it in part as a job-creation strategy. Said Craig:

“A healthy community is one thing that has to happen before you can have a prosperous community. These kinds of jobs are the jobs that bring people here and allow them a quality of life that is appealing and inviting to young people who may otherwise consider leaving the North for more opportunities. I think some of the ideas and some of the jobs that will emanate from the health-care sector that’s going to evolve in this community will be the largest economic driver that we have, surpassing mining, education, and whatever else we’ve had in the past or present.”

It is not clear yet whether the federal government will accept Romanow’s recommendation on centres of excellence.



VANCOUVER STUDY: WAR ON DRUGS IS A BUST

The results of a study of drug users in Vancouver casts doubt on supply-side efforts to curtail drug use, according to the authors of an article on the study published in the January 21 edition of the *Canadian Medical Association Journal*. The study looked at two groups of heroin users in Vancouver: a group that used heroin before a major heroin drug bust in the city (the largest bust in Canadian history), and a group who used drugs after the seizure. The authors state:

"We found no difference in the extent to which participants in the 2 groups reported daily use of heroin, frequency of nonfatal overdoses, or whether law enforcement had affected their source of drugs or the types of drugs available on the street. Although we detected no difference in the price of cocaine, the median reported price of heroin went down after the seizure, which suggests that other shipments compensated for the seizure. External evaluations of deaths from overdoses and heroin purity indicated that the seizure had no impact, nor was any impact seen when the periods of analysis were extended... The data presented here indicate that the record seizure of heroin in autumn 2000 appeared to have no impact on injection use of heroin or on perceived availability of heroin. Furthermore, we detected no difference in the extent to which drug users reported that enforcement had affected their drug source, the types of drugs available or their pattern of drug use."

The authors conclude:

"Our findings raise serious questions about the potential for Canada's present drug policies to adequately control the drug use epidemic through supply-side interventions. It is critical to emphasize our view that fault does not lie with the front-line law enforcement officers who are involved in supply-side strategies at the operational level. Rather, the responsibility lies with the politicians and policy-makers who continue to direct the overwhelming majority of resources into failing supply-reduction strategies, despite the wealth of scientific evidence demonstrating their ineffectiveness."

The article, *Impact of supply-side policies for control of illicit drugs in the face of the AIDS and overdose epidemics: investigation of a massive heroin seizure*, is found at <http://www.cmaj.ca/cgi/content/full/168/2/165>.

SASKATCHEWAN AWARDS HEALTH INFO LINE CONTRACT

Following an extensive tender process, Saskatchewan Health has awarded a service contract to Regina Qu'Appelle Regional Health Authority to operate Saskatchewan's new 24-hour telephone health advice line. The *Action Plan for Saskatchewan Health Care* endorsed the telephone advice line as an innovative, efficient way to ensure that Saskatchewan's residents have immediate access to health advice. Calls will be answered by registered nurses who can assess symptoms, provide health information or advice and help callers choose the most appropriate source of treatment for their health concerns. The process of recruiting nurses to staff the service will begin shortly. The service is expected to begin operating in the summer of 2003.

NEW BRUNSWICK ISSUES CLIMATE CHANGE DISCUSSION PAPER

In January, New Brunswick issued a discussion paper on climate change, aimed at getting New Brunswickers to comment on ways the province might deal with greenhouse gas emissions in light of the Kyoto Protocol. The paper points to possible effects of global warming on the province, as well as the level to which New Brunswick already contributes to greenhouse gas (GHG) emissions:



"New Brunswick's long coastline makes us particularly vulnerable to the impacts of climate change. Storms and rising seas would damage coastal bridges, wharves, roads, buildings and properties. Long-lasting drought or intense flooding could affect our drinking water supplies, agriculture, and the health of our forests, natural resources on which we are economically dependent.... New Brunswick releases about 20 million tonnes of GHG each year. A small part comes from landfills and agriculture. Over 90% of the emissions are energy related from the burning of fossil fuels. Electricity generation and transportation account for three-quarters of the total energy-related emissions, with much of the remainder coming from energy used in industry and in commercial and residential buildings."

The paper proposes five elements as the core of the province's plan:

- *government leadership* – practicing energy efficiency in government buildings, vehicles and equipment purchases, purchasing "green" products and services, and implementing appropriate incentives, regulations and tax treatments.
- *enhancing awareness and understanding* – providing information about how climate change is affecting the province, to encourage involvement by all of parts of society
- *technology research, development and innovation* – stimulating new and advanced technologies and innovative approaches.
- *investing in knowledge* – analyzing impacts, costs and effectiveness of different options
- *working with partners* – developing practical, effective approaches by working with partners: other governments, industry, communities, organizations and individuals.

The provincial government will hold workshops this winter with key stakeholders, focused on the overall direction of a provincial plan. Reports on the response from the public and the workshops will be released in the spring of 2003.

The discussion paper is available as a 52 page PDF file at [http://www.gnb.ca/0085/Climate_Change/ClimateChange\(Eng\).pdf](http://www.gnb.ca/0085/Climate_Change/ClimateChange(Eng).pdf).

NORTHERN PREMIERS WANT GUN LAW SUSPENSION

The Premiers of Nunavut, the Northwest Territories and the Yukon have collectively called for the suspension of the federal government's gun control program, saying the expense of administering the program and the lack of evidence that the legislation is working to prevent armed crime has forced them to speak out against this federal law that created the gun registration program. They have called for Ottawa to reconsider the registry until the effectiveness of the program can be audited and a true sense of the program's effectiveness can be determined. Said Yukon Premier Dennis Fentie:

"The North has always been very clear on our views to the C-68 gun control legislation and the differences between rural and urban Canada. The people of the North and their use of firearms is dramatically different than Canadians in urban centres. But wasting a billion-plus dollars effects all Canadians equally."



Manitoba's Attorney General Gord Mackintosh has called on the federal government to scrap its gun registration program altogether, following Ottawa's announcement that it is hiring a consultant at a cost of \$92,000 to review the registration program.

MANITOBA ISSUES HEALTH SERVICE GUIDE

On January 20 Manitoba announced it would mail the province's Infohealth Guide to all Manitoba homes in the next three weeks. The guide provides general information about the province's health care system and is broken down into three sections:

- *at a glance* – a quick reference to key phone numbers and emergency information within Manitoba's health care system.
- *health services* – information highlighting the type of health care services provided and available within the province's health system.
- *health care rights* – information on the rights, responsibilities and protections available through the health care system.

Examples of the type of information available from the guide include how to find a doctor, how to get a Manitoba Health card, what services Manitoba Health does not cover, when to visit an emergency room, ambulance service coverage, health care coverage when out-of-province, requesting home care, applying for a personal care home, vision and eye care coverage, and how to apply for pharmacare.

The Guide is also available on the internet at <http://www.gov.mb.ca/health/guide>.

YET AGAIN: POVERTY – HEALTH LINK

In an article in the December/January issue of the *CCPA Monitor*, the newsletter of the Canadian Centre for Policy Alternatives, Dennis Raphael – health policy and management professor at York University – takes aim at health promotion efforts that concentrate on lifestyle factors, rather than on improving socioeconomic status, as the way to improve health. Citing an October 2002 *British Medical Association Journal* article on predictors of heart disease, Raphael says:

“Research since the mid-1970s has found lifestyle and biomedical factors account for only a small proportion of whether someone develops heart disease or diabetes. In fact, Health Canada and Canadian Public Health Association policy statements of the past 25 years outline what really matters for disease prevention: adequate income, shelter, food, employment and working conditions, and a social safety net.... Indeed, many researchers have noted that trying to prevent lifestyle illnesses by changing adult lifestyle behaviours is unlikely to profoundly alter the incidence of heart disease and diabetes if no change is made in the improvement of people's economic conditions. Poverty influences health by determining the level of material resources available such as income, shelter, food, etc., stress that threatens bodily functioning and the adoption of unhealthy coping behaviours such as poor diet, smoking and alcohol use. These factors – the social determinants of health – are clearly not under individual personal control. They're not choices people make. Is it a lifestyle choice to have poor parents or be homeless or hungry because of low social assistance or minimum wage levels?... Wouldn't we also expect that public health, health care, and heart and diabetes associations would consider how social and economic conditions affect health? And yet, we hear little from these sources except to be preached



to about the importance of making 'healthy lifestyle choices,' even though these behaviours are relatively unimportant to the health of Canadians.... Who benefits from such neglect? Governments that weaken the social safety net, transfer wealth from the poor to the wealthy through income tax reduction and privatize public services create the risk conditions that lead to heart disease and diabetes."

The British study Raphael cites suggests that the degree of insulin resistance (a significant contributor to heart disease and to Type II diabetes), blood cholesterol levels, and obesity among 4,286 adult women were best predicted by the women's socioeconomic circumstances, and particularly by low socioeconomic circumstances the women faced as children.

Editor's note: for those interested in the connection between social determinants and heart health, a multi-sponsored one day conference on the subject, with an international roster of speakers, will be held at York University on February 20. More on the conference can be found at <http://www.yorku.ca/wellness/heartforum>.

US CURBS MEDICARE DEMANDS: DON'T TELL THEM ABOUT IT

According to a January 25 *New York Times* article, the cash-strapped US federal Medicare program that provides and administers health care funding for US seniors has found an innovative way to curb demand – by simply banning education of consumers about their rights. A December 24 memo signed by two senior Medicare officials ordered all "contractors" (usually insurance companies providing Medicare benefits) to cease all "customer service plan functions" (i.e. all efforts to educate seniors about their entitlements). The *Times* article is at <http://www.nytimes.com/2003/01/25/national/25MEDI.html?todayshadlines>.

CATHOLIC AID AGENCY OPPOSES IRAQ WAR

Caritas Internationalis, the Roman Catholic Church's international social development agency, has launched a campaign against war in Iraq and against the ongoing economic sanctions imposed on the country, arguing that a war would precipitate a humanitarian catastrophe. Said Caritas in a January 21 media release:

"Caritas shares the view held by many humanitarian organisations that any use of military force in Iraq would bring incalculable costs to a civilian population that has suffered so much from war, repression, and debilitating economic sanctions. Caritas Internationalis has never ceased appealing to the international community to suspend sanctions and end the economic blockade. With this appeal for peace, Caritas has aligned itself with the many religious and civil society leaders throughout the world who convincingly argue for a diplomatic solution to the current crisis. In Iraq today, between 14 and 16 million persons (two thirds of the population) are entirely dependent on food rations distributed under the UN Oil-for-Food-Programme, purchased through the sale of Iraqi oil. In the event of a conflict and the inevitable destruction of communication and transport infrastructures, Caritas fears the whole distribution system would break down leaving millions without food."

Development and Peace, the Canadian social development arm of the Catholic church, has urged Canadians to sign the Project Ploughshares on-line petition calling for a peaceful solution to the Iraq crisis. The petition is at <http://www.openconcept.on.ca/ploughshares/signupform.php>. Project Ploughshares is an ecumenical peace initiative of the Canadian Council of Churches.

Editor's note: According to a January 19 *Boston Globe* editorial by Richard Horton, editor-in-chief of the British medical journal *The Lancet*:



"A confidential UN briefing paper recently estimated that in the aftermath of the conflict health supplies would be needed for 100,000 Iraqis suffering injuries, 1.23 million people deemed highly vulnerable to disease, and 5.4 million with ongoing needs. And then there is the problem of terrorism. The threat of smallpox and other bio-weapons, which could claim casualties in the hundreds of thousands or even millions, has made medicine a subject of global geopolitics."

PACIFIC ISLANDS: HEALTH RISK FROM CONDOM SHORTAGES

According to a January 20 article in the *New Zealand Herald*, a number of Pacific islands face health risks due to condom shortages. The islands have been largely spared from the HIV/AIDS epidemic due to their isolation, but changing sexual practices among young islanders have heightened the risk. According to the article, some places run out of supplies because of the Pacific islands' transport difficulties. Long delivery times and storage facilities without climate control decrease the shelf life of some products, particularly condoms.

However, the United Nations Population Fund's Pacific representative, Catherine Shevlin Pierce, places much of the blame on the shoulders of the United States for withdrawing its contribution to UNPF on the grounds that some of UNPF's funds were used to encourage abortion in China (a claim subsequently debunked). Pierce says the loss of funds has caused UNPF to cut back its program globally, including programs to provide condoms in developing nations.

The *Herald* article is at <http://www.nzherald.co.nz/storydisplay.cfm?storyID=3097109&thesection=news&thesubsection=general>.

CHINA TO TACKLE RURAL HEALTH CARE, RURAL MIGRANTS' RIGHTS

According to a January 24 *Xinhua News Agency* report, China will introduce major reforms to rural health care by fostering cooperative medical plans in rural areas. The cooperatives, similar to medical insurance, will require contributions from individual farmers as well as from central and local governments so a funding pool is built up to cover farmers' treatment costs for serious illnesses. Each province would have to choose at least two or three counties to run pilot schemes this year, Chinese health minister Zhang Wenkang said last week. It will take until 2010 for the plan to be in operation nation-wide.

Rural families were once participants in coop health systems but the introduction of market reforms led to the disintegration of many plans, and recently farmers were paying on average 90% of their medical costs compared to 60% paid on average by urban dwellers. Farm workers comprise more than 70% of China's 1.3 billion population.

China has also announced reforms to ease the plight of rural people who migrate to cities. Under current law rural migrants are not eligible for most jobs in cities, since the jobs must be given to people already registered as city dwellers. The migrants get only the lowest paying jobs and are ineligible for medical insurance, education for their children and employment contracts. New government directives will open all urban jobs to rural migrants by prohibiting job discrimination based on residency, forcing employers to sign contracts with migrant workers, and requiring police to grant urban residence permits to those who find a job. An estimated 100 million Chinese migrants may benefit from the change in government policy.



SOUTH ASIA: KILLER COLD WAVE ABATES

A cold wave that covered much of the Indian subcontinent since December has started to abate, leaving more than 1,800 dead in its wake. Near-freezing temperature in some locales have been particularly hard on the poor, living on the street or in houses with no electricity or with little money to buy electric heaters even when they do have electric power. Bihar state has declared the cold wave a natural disaster, allowing victims to claim compensation, and the state's First Minister ordered district magistrates to arrange bonfires across the state, asked the forest department to provide wood to all the districts and allocated \$US 6.26 million for distribution of free firewood and blankets to two million Biharis.

JOBLESS WORLDWIDE TOPS 180 MILLION: WORKING POOR TOTAL 550 MILLION

According to an International Labour Organization (ILO) report issued on January 24, the ranks of the worlds' unemployed swelled by 20 million between 2000 and the end of 2002. Said Juan Somavia, ILO's Director-General, *"The world employment situation is deteriorating dramatically. While tens of millions of people join the ranks of the unemployed or the working poor, uncertain prospects for a global economic recovery make a reversal of this trend unlikely in 2003."*

The ILO report says women and youth have been hard hit because they often hold jobs that are vulnerable to economic shocks. As well, unemployed workers pushed into informal jobs in search of work faced even more uncertainty due to the sector's near total lack of unemployment or social security coverage.

At the end of 2002 the number of working poor, or workers living on \$1 or less a day, resumed its upward trend, returning to the level of 550 million recorded in 1998. While the global economic slowdown and post September 11 developments increased unemployment worldwide, Latin America and the Caribbean were hit hardest, with recorded joblessness rising to nearly 10%. The report estimates that to absorb new entrants into the labour market and reduce working poverty and unemployment to meet the UN goal of cutting extreme poverty in half by 2015, at least one billion new jobs are needed in the coming decade.

The report *Global Economic Trends* can be retrieved as a 118 page PDF file through ILO's media release page at <http://www.ilo.org/public/english/bureau/inf/pr/index.htm>. ILO is a United Nations specialized agency that seeks the promotion of social justice and internationally recognized human and labour rights.

GATES FOUNDATION GIVES GLOBAL HEALTH GRANT

The Bill and Melinda Gates Foundation has announced a \$US 200 million grant to establish the Grand Challenges in Global Health initiative, a major new effort and partnership with the US National Institutes of Health. The initiative will identify critical scientific challenges in global health and increase research on diseases that cause millions of deaths in the developing world. According to a media release on the grant, only 10% of medical research is devoted to the diseases that cause 90% of the world's health burden.

An international scientific board will guide the initiative and will identify and publish a focused set of critical problems, or "grand challenges," in global health, that – if solved – could lead to important advances against diseases of the developing world. The initiative will then provide competitive grants of up to \$US 20 million to teams of scientists around the world to search for solutions to each challenge.



A media release and backgrounder on the initiative can be accessed at <http://www.gatesfoundation.org/globalhealth/wef2003/default1.htm>.

OUR NEXT DOOR NEIGHBOUR IS EVERYONE: OLD LION, NEW JOB

When politicians leave office – by choice, or because the electoral process moves them on – some find a new social mission for themselves. Jimmy Carter did it by embracing Habitat for Humanity and Kenneth Kaunda, long-serving President of Zambia until 1991, is doing it by tackling one of the most distressing aspects of southern African life – the plight of AIDS orphans. Spurred in part by his strong Christian roots and influenced by his son, a Zambian physician, he founded the Kenneth Kaunda Children of Africa Foundation.

The Foundation started providing service in late 2000. One of its early initiatives involved visiting children at home to offer nutritional, medical, and other services. Another is a program of pre-school activities providing 160 children aged three to six with uniforms, food, tuition and medical attention. Recently the Foundation took over the operation of a 30-bed clinic where testing and treatment of children are among the services offered. The Foundation also works with private corporations and the governments of Zambia and South Africa to establish programs that will distribute dietary supplements and modular resource recovery units.

A Foundation priority is the development of an outreach centre at Kafue, a populous rural community near Lusaka, the capital of Zambia. It will house a school for children aged six to twelve, provide medical and educational services, and offer vocational training, economic development and community interaction. The Foundation sees the centre as a site for activities by other nongovernmental service providers (now heavily concentrated in Lusaka) and as a venue for testing multifaceted approaches to the AIDS-related problems in southern Africa.

In describing the need for the Foundation, Kaunda said:

“Every minute of every day a child dies in Africa from AIDS. Many more are orphaned. It is an enormous calamity that these children become the casualties of HIV/AIDS and are allowed to suffer beyond imaginable proportions.”

The Foundation's long-term goals include the development of:

- a research and training institute, on a site donated by Dr. Kaunda, to provide a setting for international collaboration on HIV/AIDS issues
- a series of radio stations offering educational and informational programming to help break the silence and stigma surrounding AIDS
- mobile clinics to address medical, educational and public health needs of children in the rural areas of each country
- boarding schools (starting in Zambia and South Africa) offering primary education and technical training to children who cannot attend government schools.

The Foundation is governed by an international board chaired by Kaunda and vice-chaired by the American poet Maya Angelou, and with a strong contingent of African-American religious leaders on the board. The Foundation's web site is at <http://www.kaundachildrenofafrica.org>.



IN MY HUMBLE OPINION: THE TAIL AND THE DOG

We in Canada may be about to engage in one of those fits of righteous self-congratulation that from time to time possess us. It is likely that in the next little while the provinces and territories and the federal government will agree on health care reforms that capture most, if not all, of the ideas contained in the Romanow Report. The agreement will repeat all the shibboleths that characterize our discussion of health – coordinated care, accountability, health promotion, and access. Then, for a time at least, we will congratulate ourselves for a national job well done in the face of looming crisis. So Canadian, eh?

I fear that what we will miss, however, is the need for a national strategy to address the determinants of health beyond choice-based lifestyle determinants. There is ample global evidence that what drives ill health has much to do with socioeconomic disparity in a society, even though we are still nowhere near understanding the details of that link (nor do we seem, as a nation, particularly curious to find out what the links might be). And the value issues that underlie an examination of the social determinants of health are profound enough to make the private/public debate around health care seem like a transitory backyard squabble. These are issues of whether we are a society that can transform the very way we see our relationships to each other – whether we believe there are winners and (regrettably) losers in what should be an essentially competitive society, or whether we are all “in this together”, so that the fate of the poorest and most excluded among us is inextricably linked to the fate of all of us. One of the most hypocritical scenarios might be provinces, territories and the federal government crowing about “saving” our health care system while they continue to engender social, economic and environmental policies that drive ill health in the first place. And if we need a sobering reminder of what could happen, an instructive look southward is worthwhile. In a January 27 article in the *New York Times*, columnist Bob Herbert examines Miami – the poorest big city in the US, but containing within it Fisher Island, the richest neighbourhood in the nation – and poses the challenge in stark terms:

“The Miami area is the most extreme example of the economic inequality that is becoming more and more evident throughout the U.S. If the gap between the folks at the top and those at the bottom continues to grow it will at some point undermine the social cohesion of the nation. Anyone who thinks it's a good idea for the pampered elite of Fisher Island to stockpile more and more in the way of luxuries and privilege while increasing numbers of Miamians are going to bed hungry should think again.”

By all means let us make a better health care system. But keep in mind that a fair and articulating health care system will fail if it is not embedded in a fair and articulating society.

John Butler, the Agora Group

Editor's note: Bob Herbert's editorial *Falling Into the Gap* is at <http://www.nytimes.com/2003/01/27/opinion/27HERB.html?todayshadlines>.

FROM THE QUOTES VAULT

“The moment that you have protected an individual, you have protected society.”

Dr. Kenneth Kaunda, former President of Zambia and Founder/Chairperson of the Kenneth Kaunda Children of Africa Foundation, an organization working on behalf of African children orphaned by AIDS