



Import



A WEEKLY REVIEW OF DEVELOPMENTS IN HEALTH AND HUMAN SERVICES

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Vol. 3, No. 6

February 20, 2003

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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FEDERAL BUDGET IRKS CITIES

This week's a-little-bit-for-everybody federal budget raised a chorus of cries from health organizations saying the government's intentions are good, but it hasn't dug deep enough into its pockets. The budget announced \$34.8 billion for health care, to include:

- a five-year, \$16-billion Health Reform Fund to the provinces and territories to target improved primary health care, home care and catastrophic drug coverage
- \$9.5 billion in increased cash transfers to the provinces and territories
- an immediate investment of \$2.5 billion through a Canada Health and Social Transfer supplement to relieve existing pressures
- \$5.5 billion in health reform initiatives, including diagnostic/medical equipment and a six-week compassionate leave benefit under employment insurance for individuals to care for gravely ill or dying family members
- \$1.3 billion to support health programming for First Nations.



The budget also announced \$935 million over 5 years to create more day care spaces, increase the National Child Benefit by one third and add a \$60 million per year Child Disability Benefit to help low- and modest-income families with disabled children. As well, the budget allocates \$135 million each year for three years to continue to address homelessness in Canada's cities, for a total of \$405 million over three years and \$320 million over five years to enhance existing affordable housing agreements with the provinces and territories.

Municipalities have been quick off the mark in criticizing the federal government for announcing \$3 billion over ten years for municipal infrastructure improvements. Many municipalities say their sewer, water and road systems are crumbling and need a far bigger and more immediate contribution, or greater leeway to raise funds (a municipal fuel tax is often touted as a way to increase municipalities' ability to fund upgrades to their infrastructures).

The budget and a background documents are at <http://www.fin.gc.ca/budtoce/2003/budliste.htm>.

OMA CALLS FOR SMOKING BAN

On February 11 the Ontario Medical Association released a report entitled, *The Duty to Protect: Eliminating Second-Hand Smoke from Public Places and Workplaces in Ontario*. The report outlines recent medical studies proving second-hand smoke's direct links to many illnesses and it proposes three immediate actions the provincial government can take to eliminate exposure to second-hand tobacco smoke in all provincial work and public places:

- Pursue measures that will require, by law, the 100% elimination of second-hand tobacco smoke in all work and public places
- Launch a comprehensive, intensive and sustained mass media campaign about the dangers of second-hand smoke within six months, with a focus on the need for Ontario residents not to smoke in their homes
- Once legislation is adopted, create a special implementation and enforcement fund to fund enforcement personnel, launch local advertising promoting the legislation, and provide information to local residents about the new legislation.

In reaction to the report, Health Minister Tony Clement said a provincial law banning smoking in public places to replace the existing patchwork of municipal bylaws is "worthy of consideration" and "certainly a decision point for us."

OHA is calling on Ontarians to write to MPPs demanding a law banning smoking in all offices, factories and other private workplaces, and in public places like restaurants, bars and other recreation establishments. The OMA report on second-hand smoke is a 27 page PDF file at <http://www.oma.org/phealth/2ndsmoke03.pdf>.

TORONTO CHARTER FOR A HEALTHY CANADA IS ISSUED

On February 10, organizers and participants in a late 2002 York University conference on the social determinants of health issued the Toronto Charter for a Healthy Canada. Citing evidence that the sources of health and causes of illness are social and economic, the Charter urges funding for social housing and childcare and the creation of a Task Force to oversee Canadian progress on population health. Says the Charter's author Dr. Dennis Raphael (a professor at York University and an organizer of the conference):



"It must be time to provide safe, affordable housing and quality childcare to Canadian families. No longer can we expect spending on illness care to bring us better health; it is time to get our basics right. Today, we know much more clearly that good health is connected to social policy spending. Unfortunately, the Health Accord ignores this reality and it fails to ensure that Canadians are healthy enough to lower their needs for medical attention. On the bright side, we want the new national health council to include a task force that will focus on these population health issues."

The Charter says:

"The conference recommends that Canada's federal and provincial/territorial governments immediately address the sources of health and the root causes of illness by matching the \$1.5 billion targeted for diagnostic services in the Romanow Report on the Future of Health Care in Canada and allocating this amount towards two essential determinants of health for children and families: 1) affordable, safe housing; and 2) a universal system of high quality educational childcare.... The federal government should establish a Social Determinants of Health Task Force to consider these findings and work to address the issues raised at this conference. The Task Force would operate to identify and advocate for policies by all levels of government to support population health. The federal and provincial governments would respond to these recommendations in a formal manner through annual reports on the status of these social determinants of health."

The Toronto Charter is a 3 page PDF file at <http://www.socialjustice.org/conference/torontoCharter.PDF>.

NATIONAL STUDY: CHILDCARE LOSING GROUND EXCEPT IN QUEBEC

On the heels of the Toronto Charter's recommendation for universal, quality childcare comes a study from the University of Toronto's Childcare Resource and Research Unit, released on February 10, that says Canadian jurisdictions other than Quebec have regressed over the last decade in terms of public childcare funding. The report says:

- Provincial and territorial childcare spending outside Quebec has decreased. Total spending for childcare in the rest of Canada has dropped by about \$70 million (in constant 2001 dollars) since 1992. Ontario and Alberta were the "leaders" in reducing their spending. In 2001, Quebec spent 58% of the \$1.9 billion spent by provinces/territories on regulated childcare. Per (child) capita annual spending on regulated child care was 10 times higher in Quebec (\$980) than it was in Nova Scotia, the province that spent the least (\$91).
- Growth in childcare spaces has slowed markedly. While regulated childcare spaces grew from 371,573 to 593,430 since 1992, 70% of the growth was in Quebec.
- The labour force rate of mothers of children in all age groups continued to grow. The rate for those with children 3-5 years grew from 68% to 73.4% (1992-2001).
- Subsidy eligibility levels (in constant 2001 dollars) in seven provinces and territories dropped between 1992 and 2001. Most have not adjusted eligibility levels or adjusted them very little over the decade. Generally, parents are responsible for most of the cost of childcare.

The study, *Early childhood education and care in Canada 2001*, can be accessed in full and in summary at <http://www.childcarecanada.org/ECECC2001/index.html>.



NEWFOUNDLAND ISSUES SAFE AND CARING SCHOOLS ACTION PLAN

On February 14 the Newfoundland and Labrador government announced its Safe and Caring Schools Provincial Action Plan to address school violence. A key goal is to ensure all school districts have policies by April 2003 to address violence prevention in the schools.

The province's Department of Education has purchased a bullying prevention program developed in British Columbia that offers ideas and strategies for dealing with bullies. Entitled *Focus on Bully: A Prevention Program for Elementary School Communities* and *Focus on Harassment and Intimidation: Responding to Bullying in Secondary School Communities*, these resources are being adapted to Newfoundland's curriculum and will be provided to every school in September 2003. In partnership with the Newfoundland and Labrador Teachers' Association, the department is organizing *Critical Incident Stress Management (CISM)* training for school districts throughout 2003.

The government will also purchase a series of training videos on the *Cooperative Discipline* program for each school to be used by trainers in each board to train teachers in the program. *Cooperative Discipline* offers conflict resolution suggestions and ideas for establishing a safe and caring classroom environment. The Department of Education will also provide primary schools with copies of *Trevor and the Bully*, a book on bullying for children aged five to eight, published by the Grand Falls-Windsor Committee Against Violence. This includes a large book for teachers to read to students and several smaller books that students can borrow to share with parents and caregivers.

The Action Plan is at www.gov.nf.ca/edu/pub/actionplan.pdf.

NOVA SCOTIA AWARDS KICK-START MENTAL HEALTH FUNDS

On February 10 Nova Scotia announced six one-year mental health grants to volunteer groups in the province to operate community awareness and support programs:

- public education on eating disorders (\$31,000) to Eating Disorders Community Support, in Yarmouth
- a mental health advocacy skills program (\$40,000) to Strengthen Our Sustainability, in Inverness
- postpartum depression support (\$11,700) to the Parent Resource Centre, in Dartmouth,
- schizophrenia education kit (\$40,000) to the Schizophrenia Society of Nova Scotia, in Dartmouth
- parents' resource library (\$15,500) to Parents' Place, in Yarmouth
- advocacy and leadership skills program (\$11,700) to the Depression, Manic Depression and Family Support/Self-Help Society (DMAFS) of Nova Scotia.

The province's health department invited proposals from community groups in September 2002. Seventy-two organizations asked for information kits. Twenty-three applied for funding, and six were successful.

MANITOBA ANNOUNCES CARDIAC CARE REVIEW

On February 11 Manitoba's Health Minister announced an external review will be conducted into cardiac care in the Winnipeg Regional Health Authority (WRHA). This came the same day as a news report of the death of a 58-year-old woman who had waited more than two years for surgery to repair blocked arteries after a 1995



heart attack. The review will examine co-ordination, operation and quality of all aspects of cardiac care including cardiology, cardiac surgery, anaesthesia and critical care, co-ordination and management of cardiac surgery wait lists; and cardiac care program staff recruitment and retention. The review will be led by the Edmonton Cardiac Sciences Program.

As well, WRHA will conduct a case-by-case review of the current cardiac surgery wait lists at the Health Sciences Centre and St. Boniface General Hospital to ensure that patients are prioritized appropriately. Funding of \$600,000 will be provided for a permanent expansion of the WRHA Cardiac Surgery Program and co-ordination of critical care units including availability of beds for post-surgical care at St. Boniface and Health Sciences will be improved and streamlined to reduce elective cardiac surgery cancellations.

NORTHWEST TERRITORIES ENACTS NEW IMPAIRED DRIVING RULES

On February 17 NWT introduced Motor Vehicles Act amendments to toughen penalties for impaired driving, but also to recognize the value of assessment and treatment for those who drink and drive. The amendments require assessing driving behaviour for repeat offenders and using medical assessments to identify potential substance use problems. Said Minister of Transportation Joe Handley, *"This holistic approach to the issue of impaired driving is consistent with this government's interest in the health and well-being of all NWT residents and respects the special circumstances of the North."*

US: MEDICATE, THEN EXECUTE

On February 10 a US federal appeals court ruled that Arkansas can force a death row prisoner to take antipsychotic medication to make him sane enough to execute. Without the drugs the prisoner, Charles Singleton, could not be put to death. A 1986 Supreme Court decision ruled against executing the "insane" since it violates the Eighth Amendment to the Constitution barring cruel and unusual punishment. The appeals court said, *"Singleton presents the court with a choice between involuntary medication followed by an execution and no medication followed by psychosis and imprisonment.... Eligibility for execution is the only unwanted consequence of the medication."*

In a dissenting opinion Judge Gerald Heaney wrote, *"I believe that to execute a man who is severely deranged without treatment, and arguably incompetent when treated, is the pinnacle of what Justice Marshall called 'the barbarity of exacting mindless vengeance.'... This leaves those doctors who are treating psychotic, condemned prisoners in an untenable position: treating the prisoner may provide short-term relief but ultimately result in his execution."*

US: AIDS A "SECURITY THREAT": BUSH BASHED FOR IGNORING GLOBAL FUND

On February 11 US Central Intelligence Agency Director George Tenet told the Senate Intelligence Committee that the international HIV/AIDS pandemic is a national security threat to the United States and could undermine the stability and economies of many other nations. Said Tenet, *"The national-security dimensions of the virus are plain: It can undermine economic growth, exacerbate social tensions, diminish military preparedness, create huge social-welfare costs and further weaken already beleaguered states."*

Meanwhile several Democratic and Republican congressional leaders as well as AIDS advocates have criticized George W. Bush's State of the Union promise of \$15 billion over five years to fight HIV/AIDS in Africa and the Caribbean (including \$10 billion in new money). Most of the money would not be flowed through the



UN Global Fund to Fight AIDS, Tuberculosis and Malaria, which already has an on-the-ground distribution system for AIDS funds even though the Global Fund is almost out of money. AIDS advocates say increased US contributions to the Global Fund would encourage other wealthy nations to donate more and could help save the Fund from "virtual bankruptcy." A collapse of the Global Fund would prove embarrassing to the US, since its Board recently elected Tommy Thompson, the US Secretary of Health and Human Services, as its new Chair. Bush's critics say the White House has serious concerns about how the Global Fund is administered and prefers bilateral programs administered by U.S. agencies because they allow the administration to closely monitor how U.S. money is used and to target help to nations that share U.S. foreign policy goals.

AUSTRALIA: BULK BILLING BY DOCTORS DECLINES

A controversy in Australia over how doctors are paid shows the complexities that arise when a jurisdiction melds user fees with universally accessible primary care.

Since medicare was introduced in Australia in 1984, doctors have been able to charge patients directly for services (including a fee above the established medicare rate), and patients can then claim a rebate based on the established medicare rate, from the government. Alternatively, doctors can "bulk bill" the government, but cannot charge above the fee schedule. Conventional wisdom has suggested doctors would prefer to bulk bill as an administrative efficiency. However, the number of doctors opting for bulk billing has declined, leading to claims that poor Australians face a disincentive to seek medical care because they must pay for part of it directly if their doctor does not bulk bill. Bulk billing rates vary across Australia, sitting above 70% in New South Wales and the Northern Territory, but less than 60% in Tasmania and the Australian capital territory.

Critics of the government (including several of Australia's states) say that in areas where bulk billing has declined, patients often seek primary care at hospital emergency departments, thereby shifting costs from the federal government to the states. They also say the rate of bulk billing is lowest in rural and remote areas where physicians maximize their income through billing to patients.

On February 10 the federal Health Minister Kay Patterson said she was working on a plan to end the inequity of some low-income patients having to pay their general practitioners while others did not, but she denied the government would involve patients in means-testing – leaving analysts puzzled about how she plans to solve the problem.

STUPIDEST HEADLINE OF THE MONTH

"Iraq War Would Hurt Auto Sales" (Los Angeles Times, February 4). The article goes on to say, *"This year's U.S. vehicle sales likely will decline 1.8 percent and possibly even more if the nation goes to war with Iraq, but should remain strong by historical standards, according to the National Automobile Dealers Association."* Said NADA's chief economist, *"Given that the preceding four years were the best in the history of automotive retailing, there's momentum for the long-run. Positive underlying economic fundamentals are working in the industry's favor."* Bill Ford, Chairman and CEO of Ford Motor Company, put the whole war in perspective when he said *"I think with the threat of international conflict hanging over the stock market, it doesn't help any of us."*



SCOTLAND ISSUES WAIT TIME GUARANTEES

In a February 11 speech, Scotland's First Minister Jack McConnell announced that patients needing cardiac surgery will wait no more than 6 months from the point of diagnosis to surgery. If the surgery cannot be performed in Scotland within that period, the National Health Service will pay for it to be done elsewhere in Europe. From 2004, Scotland will extend that guarantee to 18 weeks or less from diagnosis to surgery. For all other kinds of surgery, Scotland will guarantee a wait of no more than nine months. As well, Scotland's current target of a wait of no more than 26 weeks for an outpatient consultation by 2006 has been moved ahead one year to 2005, along with a better and more accurate system of recording and monitoring the number of people waiting for an outpatient appointments. McConnell says these guarantees will be "a fundamental right for the future". He also said the Scottish Executive will bring forward proposals soon to streamline management and devolve decision making and budgets to local hospitals and local health care units. McConnell also indicated the Scottish Executive would publish a White Paper on Scotland's health system in the net few weeks.

UNICEF REPORTS ON PLIGHT OF URBAN CHILDREN

UNICEF's Innocenti Research Centre (IRC) has released a report on the world's urban children. It paints a bleak picture, but with examples of hope. The report points out that half the world's children live in urban areas, and tries to dispel the belief that urban children are better off than rural children because of greater access to urban services:

"Hundreds of millions of urban children live in deep poverty, their rights neglected, their needs unmet, their prospects damaged by conditions that threaten their health and undermine their development. As the World Health Organization has recognized, when infrastructure and services are lacking, urban settlements are among the world's most life-threatening environments. Figures from India, where 24% of the total urban population of 285 million are classified as poor, indicate that more than half of the country's poor urban children are underweight and/or stunted; a high proportion are severely undernourished – 23% in weight-for-age and 30% height-for-age, 50% of poor urban children are only partially vaccinated, and another 18% are not vaccinated at all. More than 80% of poor children in India's urban areas have anaemia."

It cites increased inequalities within nations as a danger to children's well-being:

"Much child deprivation is linked to inequality within nations – including nations with good economic performance. According to available data, income inequality has increased in most nations, especially in Latin America and countries previously in the Soviet Bloc (which tend to be among the most urbanized of low and middle income nations). Rising average urban incomes do not necessarily mean falling child poverty: in the United States child poverty rates have increased 31% in urban areas and 50% in suburban areas since the 1970s, despite the fact that real per capita incomes are much higher today than they were in 1970. Even falling unemployment may not mean a reduction in child deprivation: in the UK, the proportion of households with children with no income earner grew between 1985 and 1996, even though unemployment levels fell."

An analysis of child poverty in rich nations shows the importance of government policies and redistributive taxes as a means of reducing poverty levels or preventing them from rising too much during periods of economic difficulty; it indicates, too, that the withdrawal of state support for the



unemployed or those on low income can increase child poverty even during periods of economic prosperity. There is no evidence that measures to keep down child poverty have an adverse effect on economic growth. Many of the world's wealthiest nations also have the lowest levels of child poverty and the highest levels of inter-governmental transfer. It is worth noting the emphasis among many nations with the lowest levels of child poverty on getting the unemployed back to work. In many low and middle income nations, governments have been ineffective in establishing social policies that improve provision for children in general and that support the most vulnerable children. The liberalizing agenda has cut the resources available to governments, but without ensuring that the poorest and most vulnerable groups are not most affected."

In terms of globalization the report says:

"The very poor economic performance of the world's low income nations and the economic deterioration in many middle income nations underlies much child deprivation. It also underpins the very large debt burdens that so many nations face. A globalizing world economy creates winners and losers, and growing inequality between nations presents particular challenges for children. Many nations have faced significant declines in per capita incomes in recent years. The situation in Eastern Europe, Central Asia and most of Sub-Saharan Africa during the 1990s has been particularly extreme. Sharp rises in unemployment, reductions in wages and, often, increases in the price of basic goods have had serious impacts upon large sections of the urban (and rural) population....."

The serious impacts on children of the macro-economic reforms promoted by the World Bank and the IMF in the early 1980s came as a surprise to most of their proponents, who had assumed that the resulting economic growth would more than compensate for short term losses. Rarely was provision made to protect the social expenditures with most importance for child development. This is still the case in many nations... Public expenditure on health is very low and stagnating in low income nations and falling marginally in middle income nations."

The report presents a series of approaches to the determinants of health that could help urban children. It also offers examples of on-the-ground approaches to urban life that can foster the well-being of children – even while the world struggles to adopt a determinants of health approach – including an example from Montreal:

"In 1990, in the neighbourhood of Little Burgundy, Montreal (population 40,000), an escalating drug trade and a high crime rate – including many violent crimes – had undermined the social fabric and created insecurity among residents. Neighbourhood groups mobilized the police, municipal departments and citizens to assess the situation and identify solutions. Specific measures taken by this coalition included:

- upgrading the quality and safety of public transportation; improving library services; improving street lighting; removing high fences to encourage police and citizen surveillance; and lobbying for a new sports complex to offer local youth recreational activities.*
- organizing an Environment Week to encourage citizens to improve overall conditions; creating a local newsletter; promoting greater resident participation in the annual public festival; and ensuring that the media focused attention on the revitalized quality of life in Little Burgundy rather than the outdated negative stereotypes.*



- *social development initiatives including the assistance of a social worker for families with drug problems; encouraging economic investment, development, and job creation (e.g. favouring the employment of local people to run the new sports complex); and promoting cultural tolerance.*

Over a three year period, there was a 46% reduction in reported crimes and a 45% drop in reported violent crimes. Residents began to make greater use of streets at night, and parents no longer felt the need to escort their children to school. Partners in this effort included Montreal's housing authority, various municipal departments, the police service, neighbourhood organizations and residents. Funding was provided by various departments of the City of Montreal, departments of the government of Quebec, and advertising revenue generated from the local newsletter."

The UNICEF report, *Poverty and Exclusion among Urban Children*, is found as a 34 page PDF file at <http://www.unicef-icdc.org/publications/pdf/digest10e.pdf>.

UN TO HELP CURB MERCURY POLLUTION

The 130-nation Governing Council of the United Nations Environment Program (UNEP), meeting in Nairobi, announced an action plan to reduce mercury emissions globally, saying, *"there is sufficient evidence of significant global adverse impacts from mercury and its compounds to warrant further international action to reduce the risks to human health and the environment"*.

Under the action plan UNEP will offer help to all countries, particularly developing ones and countries with economies in transition such as former states of the Soviet Union, in cutting mercury emissions from sources such as coal-fired power stations and incinerators. Measures may include advising countries on cleaner coal methods, improving the efficiency of power stations and giving advice and help on switching to other forms of electricity generation, including renewables such as wind and solar power. UNEP will also help countries to reduce other sources of mercury pollution, including contaminated waste sites and dental amalgams and equipment. The agreement also calls for UNEP to help develop public awareness programs to alert the public to the risks, especially vulnerable groups such as pregnant women and babies, and workers and communities involved in small-scale gold and silver mining.

The mercury decision follows discussions on a global assessment report, compiled by UNEP and experts and presented to delegates earlier in the week, which highlighted the threat to humans and wildlife from this persistent, health-hazardous heavy metal. The report found that mercury travels across the earth at a far greater rate than previously known, circulating between the air, water and in living things. Even regions without significant mercury releases of their own, such as the Arctic, were found to be adversely affected by the global spread of mercury. Mercury has many industrial uses, although safer alternatives exist. It is used in small-scale mining of gold and silver and in thermometers, fluorescent lamps and some paints. Some skin-lightening creams and traditional medicines also contain mercury.

Many delegates pushed for an international protocol on mercury, similar to the Kyoto Protocol. US delegates opposed it, preferring a public awareness campaign, but European delegates succeeded in getting agreement that the idea of a protocol on mercury, lead and cadmium would be reviewed at a UNEP meeting in 2005.



US STUDY: PRIMARY CARE FAILS WITH CHRONIC DISEASES

A US study released on February 14 by the Progressive Policy Institute offers food for thought that may make sense in Canada as well as the US.

The study, *Healthy Aging v. Chronic Illness: Preparing Medicare for the New Health Care Challenge*, argues that US physicians are hampered, by their training and by the way the primary care system is organized and funded, in trying to help with the burgeoning array of chronic illness in the US. The study says:

“Medicare and modern medicine are badly unprepared to meet the nation's greatest contemporary health challenge: chronic illness. Diseases such as arthritis, coronary artery disease, diabetes, and asthma now afflict more Americans, cause more disability and death, and cost more money than any other health problem. Over three-quarters of the Medicare population suffers from one or more chronic conditions. In less than 20 years, care for these conditions will consume 80 percent of the nation's health care spending.

While modern medicine and public health have dramatically improved our ability to survive acute threats like heart attacks and infectious diseases, chronic conditions demand new and fundamentally different approaches than those currently offered. For well over a century, medicine has emphasized acute care. Doctors are trained to “find it and fix it.” A broken bone needs a cast. A heart attack leads to a bypass operation to correct a clogged artery. A badly infected foot is amputated.

While obviously necessary in many cases, these medical responses often represent a failure to act proactively against chronic illnesses, which are by definition ongoing and resistant to quick fixes.....

Expanding research demonstrates that so-called ‘care management’ or ‘disease management’ programs effectively and efficiently mitigate the disability, suffering, and cost associated with chronic illness. In care management programs, doctors detect and prevent deterioration and complications from chronic illnesses. Health professionals work closely with patients to develop a treatment plan, monitor progress, and assess results in a continuously improving process. Unfortunately, these programs remain stymied by the outmoded payment systems employed by Medicare and most private insurers. These systems reward doctors for doing things ‘to’ patients – procedures like heart surgery or amputation – not for working ‘with’ patients to coordinate their care, engage them in their own care, and monitor their progress. The lack of a drug benefit shows the absurd conclusion of this process. Medicare will pay once you've been hospitalized with a stroke, but will not pay for anti-hypertension drugs to prevent it.”

The study argues that the US Medicare system (a program providing care to US seniors) should be structured to promote a greater quality focus, reduction in medical errors, and enhanced information systems, bound together by physicians who are paid to coordinate care and ensure good results, and not simply for carrying out procedures.

The study is available as an 18 page PDF file at http://www.ppionline.org/documents/Chronic_Care_0203.pdf.



IN MY HUMBLE OPINION: BILL

When the wind blows a certain way in winter – raw, and in little gusts – I remember Bill.

He lived a few houses north of us, within the little enclave of Peter Street in the town of Markham. Bill was an affable man, fond of inviting neighbours into his den for a game of pool or just a sit-down in his back yard over a beer on hot summer days.

Bill was an auto mechanic. An excellent one. He had been head mechanic at a garage here in Markham, until his boss discovered him bringing bottles of rye to work in his lunch pail. The boss fired Bill.

Thereafter, for about ten years, Bill lived off whatever work he could get by fixing cars in his own driveway. No matter what the problem was, Bill seemed able to fix it. But Bill didn't do much of a job of fixing himself.

All of us in the neighbourhood knew about Bill's drinking problem. We would occasionally gossip about it when Bill wasn't around, but our gossip usually ended up with the conclusion that yes, despite his problem, Bill sure was a good mechanic.

Many of us took our broken cars to Bill. He was good, and he was cheap. His overhead was next to nothing, and lying on a rotting sheet of cardboard placed under each car, he worked on repairs all year round, even on bad winter days.

As Bill's drinking got worse, we learned he would fix our cars more quickly if we paid him with a bottle of rye rather than cash. So we bought him rye and he fixed our cars.

In the last year of his life Bill turned into a near-skeleton, a phantom-man working with his wrenches and other paraphernalia, lying on the ground even when the wind blew a certain way in winter – raw, and in little gusts. Then, he died. Bill's wife and children had no money for a decent funeral, but one of the neighbours donated a space in his family plot so Bill could have a resting place. There was no money for a grave marker.

None of us had done anything to help Bill when he was alive. Bill's problems were Bill's, not ours. None of us talked to him about his drinking. Many of us even joined him for a sociable drink after bringing our cars to his house, and we usually left before he was too drunk to stand. No one offered to go with him to a treatment centre.

This story is not about Bill's failure. It is not about alcoholism. It is about the failure of one small community to help one small man in its midst. In reality, we profited from Bill's problem. Good work, cheap.

We who profess to care about social capital, who espouse community development, who believe in the power of ourselves as fellow citizens, would do well to recognize the many Bills in our midst – people from whom we feed, people we humour for our own purposes, people we use but do not help.

And that's why, when the wind blows a certain way in winter, I remember Bill.

John Butler, The Agora Group



FROM THE QUOTES VAULT

More Words from Chairman Jean:

"A proof is a proof. What kind of a proof? It's a proof. A proof is a proof. And when you have a good proof, it's because it's proven."

Prime Minister Jean Chrétien, when reporters asked what kind of "proof" Canada wanted to see before backing a U.S. attack against Iraq