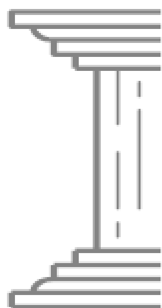

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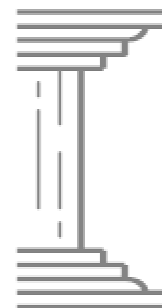

A WEEKLY REVIEW OF DEVELOPMENTS IN HEALTH AND HUMAN SERVICES

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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.*



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|---|---|
| Ontario launches budget town hall series | Canadian study: depression high in girls |
| Ontario to chase deadbeat parents | US: drinking kills kids in cars |
| Ontario to bolster workplace health and safety | US health posters displayed online |
| Ontario to cover CAS deficits | Mali to fund campaign on female genital mutilation |
| Alberta augments service for Calgary's inner city seniors | Our next door neighbour is everyone: Zambian woman fights AIDS |
| Nova Scotia develops health indicator approach | Our readers say….. |
| New Brunswick to act on child death findings | In my humble opinion: why we write this newsletter |
| Feds to back down on Aboriginal consent form | From the quotes vault |
| Quebec to meet day care goal | |



## ONTARIO LAUNCHES BUDGET TOWN HALL SERIES

On February 9 Premier McGuinty announced details of the town hall meetings he had promised earlier, as a way to give Ontarians input into government decision-making. By describing them as budget town halls the government is clearly planning to continue its efforts to put a damper on public expectations in light of the estimated provincial deficit.

Dubbed "Delivering Change", the strategy has five components:

- **Regional Town Halls**, hosted by cabinet ministers and open to the public on a first-come, first served basis by calling a toll-free hotline to register (1-866-608-4824). Many MPPs will also be holding Town Halls with local constituents.
- TownHallOntario.gov.on.ca, a web site containing information about government priorities and its current fiscal situation, as well as discussion guides for each component of "Delivering Change". In the near future the web site will give Ontarians a chance to give advice to the government online.

- **Citizen Dialogues**, day-long sessions, run by an independent organization, that take a representative group of citizens through a discussion of budget priorities and approaches. Citizens cannot volunteer to participate in these sessions: participants will be selected instead through a structured random selection process.
- **Ministry of Finance Roundtables** which bring together organizations and institutions from various sectors.

According to the government, *"This public dialogue builds on the tremendous success of the Ontario Public Service Ideas Campaign, a six-week long dialogue with public servants that generated more than 11,000 ideas for improving services while living within our means"*. Most public servants participated through the government's internal "ideas" web site, which invited them to submit ideas for changing current policies or practices or proposing new ones, along with pros and cons of their suggestion. Employees could submit ideas as individuals or in teams, and could also participate by phone, fax or mail. Seven regional conferences in January (in London, Thunder Bay, Peterborough, Sudbury, Ottawa and two Toronto locations) brought together staff from various ministries working locally, to take an in-depth look at key proposals and how to implement them. About 150 public servants took part in each conference.

## ONTARIO TO CHASE DEADBEAT PARENTS

On February 6 Ontario's Minister of Community and Social Services Sandra Pupatello announced changes to the province's Family Responsibility Office (FRO), a department that helps enforce family support payment orders. According to Pupatello, FRO will take immediate steps to:

- make the Family Responsibility Office more easily accessible to those who rely on it
- make the enforcement of support orders a priority
- track down more deadbeat parents
- make support payors understand the consequences of failing to comply
- help employers to understand their obligations in collecting support payments
- do more to reach out to clients to stop problems before they start.

The province is also issuing a pre-release of a draft request for proposals for technology that will enable FRO to implement a case management model similar to that used across North America. It would replace Ontario's outdated assembly-line approach.

Says Pupatello, *"Children should not be forced into poverty because parents have not lived up to their responsibilities. When families are forced to go on social assistance because they don't receive their support payments, we all pay. We need to make the right people pay."*

## ONTARIO TO BOLSTER WORKPLACE HEALTH AND SAFETY

On February 4 Ontario's Minister of Labour Chris Bentley announced an initiative to address what the government calls an alarming increase in construction deaths. Bentley is establishing the Minister's Health and Safety Action Group, which will begin by examining health and safety in each of the construction,

health and manufacturing sectors. Other panels will be assembled as required. Starting with construction, it will enlist experts by sector to identify best practices, programs and policies and then join with employers, unions and workers to implement them swiftly. The first meeting of the construction panel will be February 12, 2004.

Says Bentley, *"Construction fatalities increased 50 per cent in Ontario in 2003. There were 30 construction deaths last year, the highest level in more than a decade. Across all sectors almost 100,000 people suffered injuries severe enough to force them to miss time at work. Another 185,000 were injured but remained on the job".*

A media release on the initiative is at http://ogov.newswire.ca/ontario/GPOE/2004/02/04/c6588.html?lmatch=&lang=_e.html.

### ONTARIO TO COVER CAS DEFICITS

On February 4 Ontario's Children's Services Minister, Dr. Marie Bountrogianni, announced a funding award of $64 million to be distributed to the children's aid societies to address in-year operating needs. Bountrogianni also made a commitment to work with children's aid societies to bring greater sustainability and accountability to the system. She indicated the focus will be on achieving positive results for children, including finding permanent families for more children and helping prevent abuse before it starts.

CASs in Ontario have long complained of an inadequate funding formula that does not recognize CAS costs related to prevention activities.

A media release on the award is at http://www.children.gov.on.ca/CS/en/newsRoom/newsReleases/040204.htm.

### ALBERTA AUGMENTS SERVICE FOR CALGARY'S INNER CITY SENIORS

On January 19 Alberta announced that provincial grants, augmented with supplemental funding, will allow Calgary's Alex Seniors Community Health Centre to work with other health providers to develop and deliver programs that meet the needs of lower income seniors in the inner city. Many of these seniors have complex health needs and are isolated, facing personal and social barriers that inhibit their ability to seek regular medical checkups. Half the seniors who will use the Centre will not have had a medical exam in the past year.

A team of six family physicians, a registered nurse, nurse practitioner, licensed practical nurse, outreach counselor, and recreational therapist will provide services from a new facility that *provides "a fresh, bright location that is a comfortable and friendly alternative to a hospital emergency room".*

The Alex Seniors Community Health Centre web site is at http://www.thealex.ca/seniors.

### NOVA SCOTIA DEVELOPS HEALTH INDICATOR APPROACH

After two years of developmental work Nova Scotia's Provincial Health Council has completed the last of twelve documents on indicators of health, and has provided the results of its work to Health Minister Angus MacIsaac.

The indicators project developed 150 indicators within twelve categories: biology and genetic endowment, culture, education, employment and working conditions, gender, health services available, healthy child development, income and social status, personal health practices and coping skills, physical environment, social environments, and social support networks. The twelve indicator reports are available at http://www.healthcouncil.ns.ca/publications/determinants.html. The data collected for each of the indicators will be used to report to Nova Scotians about their health and will allow comparisons of the health of Nova Scotians to the health of residents in other provinces and other countries. The database will be updated over time, allowing tracking of changes in the health status of Nova Scotians.

Based on these indicators the council is beginning "life cycle" review, which will use the indicators to examine the health of Nova Scotians. A report will be released in each of the next four years looking at the health status of one age group: children and adolescents, young adults, mature adults, and seniors. In the fifth year of the process, a report will be released on health issues that are of concern to all age groups. The cycle of reports will then be repeated. Over the next few weeks the council will hold a series of focus groups in communities across the province to gather feedback on a draft of the first report, which looks at the health status of children and adolescents. The final version of that report will be released in the spring.

## NEW BRUNSWICK TO ACT ON CHILD DEATH FINDINGS

On February 5 the New Brunswick government released its preliminary response to the findings of its Child Death Review Committee, which proposed two recommendations to ensure the safety of young children in situations similar to that which led to the death of James Waddell of Saint John in 2003. The four year old boy was killed by three Rottweilers that belonged to a friend of the boy's father. The friend was living with the Waddell family at the time. The Child Death Review Committee recommended that:

- A risk assessment should be made when an additional adult begins to live in the dwelling of the child under protection.
- In cases where the child under protection is of tender age, a risk assessment should be made when harm may be caused by an animal housed in or around a building.

The province's Department of Family and Community Services says it is reviewing the guidelines for completion of its risk assessment instruments, as well as routine in-service training for social workers that is meant to increase awareness of risks that animals pose around small children. A media release on the issue is at http://www.gnb.ca/cnb/news/fcs/2004e0133fc.htm.

## FEDS BACK DOWN ON ABORIGINAL CONSENT FORM

In an example of the power of passive resistance, Health Canada has backed down on its plan to require Aboriginal people covered by the Non-Insured Health Benefits (NIHB) Program to sign consent forms for the release of medical information. NIHB provides medical coverage for Aboriginal people for medical costs – including prescriptions – not covered by provincial or territorial health plans. Earlier, Health Canada had set a deadline of March 1 for Aboriginal people to sign the consent forms or face a requirement that they pay the health costs themselves, to be reimbursed later by the government. Bolstered by objections from Aboriginal organizations that the forms constituted an invasion of privacy, very few Aboriginal Canadians had signed the forms.

Health Canada now says that:

> *"In a few instances, where client safety or inappropriate use of the system may be a concern, the NIHB Program will seek the express consent of clients to share their personal information with health care providers. This consent may be provided verbally or in writing. In a few cases, NIHB may refuse to pay for prescriptions until a patient safety plan is in place."*

**QUEBEC TO MEET DAY CARE GOAL**

On February 6 Quebec's Family Minister Carole Théberge announced that 11,960 new day care spaces will be available to children by March 2006. The spaces will be mainly for under-serviced regions, handicapped children and children from low-income families. This will bring the total number of day care spaces in Quebec to 200,000, the target established by the previous Parti Québécois administration in 1997. The Liberals under Jean Charest have been reluctant to tamper with this popular program, although as part of government belt-tightening Quebec's Liberal administration increased the per diem paid by parents from $5 to $7 in January.

The government's share of costs for day care in Quebec now tops $1 billion per year.

**CANADIAN STUDY: DEPRESSION HIGH IN GIRLS**

A study headed by University of Alberta researcher Nancy L. Galambos and published in the January issue of the *International Journal of Behavioral Development* shows high rates of severe depression among girls aged 12 to 19. The study, entitled *Gender differences in and risk factors for depression in adolescence: A 4-year longitudinal study*, analyzed four years of data from 1,322 boys and girls. The data showed that more than one in five girls admitted to having been depressed sometime in her life, while only one in 10 boys said they had ever been depressed. More alarmingly, during each year of the study nearly one in 10 teen girls had a major depressive episode (about twice the rate of boys).

Says Galambos, *"This is a substantial number of young Canadian women who should be identified as depressed and treated. Very substantial proportions of young people will experience a major depressive episode at some point as they move through adolescence."*

Galambos also notes that depression puts teen girls at risk of anxiety, eating disorders, conduct problems, academic failure and trouble with relationships. Smoking was also linked to depression. Girls who smoked were 40% more likely to report a major depression during the study. Galambos said, *"It might be that some people are smoking to self-medicate because they already feel bad. It's an interesting two-way relationship between smokers and depression that needs further investigation."*

**US: DRINKING KILLS KIDS IN CARS**

Data analysis recently released by the US Centers for Disease Control (CDC) shows that in the period 1997-2002 an average of 390 children who are passengers in motor vehicles die annually in alcohol-related crashes in the US. In almost 70% of the crashes, the driver had a blood alcohol level above the acceptable legal level in most US states. And the higher the blood alcohol level of the driver in these child-

killing crashes, the more likely it was that the child passenger was not restrained by a seat belt or other device.

In addition to better screening and treatment for people with alcohol problems, the CDC report suggests that lower legal blood alcohol limits for drivers transporting children, as well as child endangerment laws that apply to persons who drive while intoxicated with a child in the vehicle (already on the books in 35 states) may reduce the number of child fatalities from drinking and driving.

An article on the CDC's findings is found in the February 6 edition of *Morbidity and Mortality Weekly Report* at http://www.cdc.gov/mmwr/PDF/wk/mm5304.pdf.

### US HEALTH POSTERS DISPLAYED ONLINE

The US National Library of Medicine has the world's largest collection of poster art dealing with questions of health, and now a number of these posters can be viewed online, with descriptive text putting each poster within its historical context and explaining why each poster was effective. The posters are grouped into four categories: infectious disease, environmental health, anti-smoking campaigns and HIV/AIDS. The online poster collection can be accessed at http://www.nlm.nih.gov/exhibition/visualculture/vchome.html.

### MALI TO FUND CAMPAIGN ON FEMALE GENITAL MUTILATION

At a recent UNICEF-sponsored meeting of officials from the government of Mali with local advocacy groups, the government agreed to work with local activists and religious leaders in mounting a grass roots public campaign against female genital mutilation (also called female circumcision). Mali has one of the world's highest rates of female genital mutilation. At least 95% of the West African country's female population have undergone the procedure, which can lead to infertility, reproductive tract infections, obstructed labour and increased susceptibility to HIV/AIDS, hepatitis and other blood-borne diseases. Some local and international activists have demanded that Mali make female genital mutilation illegal – a move the government is unlikely to make given the degree to which the custom is embedded in the nation's culture. As well, the government fears that making it illegal would convert it into a clandestine cultural practice in which women and families are less likely to seek help dealing with botched attempts at mutilation.

According to Dr. Heli Bathija of the World Health Organization, government-sponsored grass roots campaigns against the practice have had some success in Kenya, Uganda, Burkina Faso, Egypt and Senegal, and similar campaigns have been established in Guinea and Sudan. However only 16 African nations have laws preventing female genital mutilation.

Between 100 million and 130 million African women have endured FGM or excision at the hands of unqualified practitioners, often without any anaesthetic or sterilized instruments. On February 6 Canada's ambassador to Ethiopia, Rosaline Murray, was one of nine female ambassadors to Ethiopia who signed a letter in support of World Health Organization efforts to combat female genital mutilation. Murray's action was consistent with Canada's recent announcement that violence against women is high on its international agenda for 2003. As Canada's Minister of Foreign Affairs Bill Graham said in a February 2 speech to NGO's in Ottawa:

> *"On women's rights, Canada will again be leading a resolution on the elimination of violence against women. We intend to work together with like-minded countries to counter the trend toward political and cultural polarization of women's rights that we witnessed at last fall's [United Nations] General Assembly, where only a resolution on domestic violence was adopted."*

**OUR NEXT DOOR NEIGHBOUR IS EVERYONE: ZAMBIAN WOMAN FIGHTS AIDS**

Twenty-eight year old Princess Kasune Zulu has talked to George W. Bush about AIDS. She has also disguised herself as a prostitute and talked to long-distance truckers in her native Zambia about the disease as she hitchhiked her way across the country. And she is well known among Zambians as host of the phone-in radio program *Positive Living* that gives Zambians a chance to talk about how they deal with HIV/AIDS – something many people have been reluctant to do in a country where AIDS is often an unmentionable subject.

Zulu (whose name Princess is a given name, not a title) has qualifications. She is HIV positive. Her mother and father were dead of AIDS by the time Zulu was 14, and one brother and one sister have died of AIDS (the sister died at the age of 2). Zulu was born into a wealthy Zambian family whose assets were eaten away by coping with medical bills. Zulu was reduced to carrying her father to the nearest clinic, 10 kilometres away. Says Zulu, *"I carried him on my back because he was too sick to walk. He was taller than me and his feet dangled on to the ground".*

To help support the remaining family, at age 17 she married a much older man whose two previous wives had died of AIDS and who is HIV positive himself. Although Zulu and her husband are now divorced, their two children are HIV-free.

Buoyed by a deep religious faith, Zulu began speaking in public in Zambia in 1997 about her condition and forging links with others who had HIV/AIDS, although initially both her church and her husband opposed her openness about the disease. Zulu established two foundations to help children orphaned or affected by HIV/AIDS, as well as a support group in her community. In 1997 Princess and her husband gave up their large house in Zambian city of Luanshya to establish a community school called the Fountain of Life, serving 200 AIDS orphans and other children.

In 2001 she joined World Vision's HOPE Initiative, a program to fight the spread of HIV/AIDS and care for its victims. HOPE Initiative's web site is at http://www.worldvision.org/worldvision/appeals.nsf/stable/hope_home?OpenDocument.

Zulu facilitates health education with the young and old, with a special focus on women. She has also been involved in developing partnerships with churches and she promotes volunteer counselling, teaching and awareness of mother-to-child transmission. Zulu shared her story at the 14th Annual International AIDS Conference in Barcelona in July 2002. In April 2003 she met with George W. Bush and Secretary of State Colin Powell to urge the US to make a greater commitment to AIDS initiatives in Africa.

Her commitment to the HIV/AIDS struggle has also led her to a deeper understanding of the plight of African women:

> *"We are late in tackling the AIDS epidemic, but we can stop it. Changing the lot of women is the key to turning things around. Not enough women are empowered. Not enough of them are*

> *educated about AIDS and not enough of them have their own home or a job which would help them assert themselves. It's hard for a woman to make her husband use a condom if he refuses to and if her husband dies of AIDS, and she suspects he has infected her, she may well keep quiet about it because she needs to remarry in order to survive."*

Zulu's identification of the link between AIDS and gender has been amplified more recently through the launch of the UN-sponsored Global Coalition on Women and AIDS. As the new organization said in its inaugural February 2 media release:

> *"Existing HIV prevention and protection efforts are failing to stem infections among women and girls because they do not take into account such issues as gender relations and sexual behaviour.... Women are particularly vulnerable to HIV, with about half of all HIV infections worldwide occurring among women. This vulnerability is primarily due to inadequate knowledge about AIDS, insufficient access to HIV prevention services, inability to negotiate safer sex and a lack of female-controlled HIV prevention methods, such as microbicides... They may be coerced into unprotected sex or run the risk of being infected by husbands in societies where it is common or accepted for men to have more than one partner. Women are also biologically more vulnerable to infection: male-to-female HIV transmission is estimated to be twice as likely as female-to-male."*

Zulu's view of her own life – and its future – are clear: *"I am doing the best I can to live my life and make a difference now. I don't want to die before I'm dead."*

**OUR READERS SAY…..**

In response to a series of articles in *Import* about attempts by the US government to stifle importation of pharmaceuticals into the US, and in response as well to accusations from US Senator Orrin Hatch that these prescriptions filled in Canada for US patients are unsafe, a reader (who is also a physician) wrote:

> *"So let me get this straight. The US Food and Drug Administration, backed by influential people such as American Senator Orrin Hatch, argues that it is (in Senator Hatch's words) 'irresponsible for Congress to jeopardize public safety by allowing the unchecked importation of drugs (from Canada)' and expose Americans to 'what amounts to pharmaceutical Russian roulette' (Time, February 2 2004).*
>
> *Therefore, Senator Hatch and the FDA must know of hordes of Canadians who have been injured and killed from use of counterfeit or faulty medications sold, and by implication made in the backward Great White North. Except that there haven't been any at all, or for that matter Americans, as supported (for example) by FDA Associate Commissioner William Hubbard under testimony to a 2003 congressional committee (Time, ibid). In fact, Canadians' health outcomes, despite our significantly harsher winters and longer distances for many to reach medical care, are better for the most part than those of Americans.*
>
> *Whereas all Canadians have health insurance, there are more US citizens with no health insurance than there are Canadians, 'period'. And many Canadians have personal additional drug cost insurance, whether through one's employer or paid oneself. And if your drug and other family health expenses are above a certain amount, you can deduct that added cost from your federal*

*income tax. And Canada's federal government regulates all pharmaceutical prices, and thus profits. 'Public safety', Senator Hatch? Who's kidding who? Your pharmaceutical emperor is naked.*

*And by the way, it is illegal for drug companies to sponsor election campaigns in the Great White North. That makes it considerably more difficult for them to...er...hatch and lobby to sustain profit schemes at the expense of Canadian citizens' incomes, and their health."*

## IN MY HUMBLE OPINION: WHY WE WRITE THIS NEWSLETTER

Just over three years ago we sent out our first edition of *Import* (January 15 2001 to be precise) to about two hundred recipients. Our mailing list today is about one thousand. Now is probably a good time to explain why we started writing *Import*, why we keep doing it, and why we hope you will keep reading it.

Let me start with the name ***Import*** and its double meaning. "Import" is a synonym for "significance" (as in "this information has import") and it is the root of the word "important". Despite our dalliance with the occasional piece of odd news, we like to think that what we include in each edition is significant, now or in the near future.

But the name also reflects our belief that human service systems can become incestuous in terms of knowledge. It is too easy to learn only from like-minded, like-experienced people. This first struck me years ago when I spent hours in an extended lunch with a group of powerful hospital CEOs. The environment and circumstances of the lunch offered a chance for them to talk about important things, critical things that affected the wellbeing of the people they served, things that lay in the fields of politics, social organization, economics, ethics. But the conversation was about the merits of different hospital parking garage configurations and the usual scuttlebutt about who was applying for what CEO position at which hospital.

I'm not picking on hospital administrators. The same discussions go on everywhere among all professions, and I have taken part in these discussions as much as anyone else. But because the human services system (particularly the health system) is powerful, it can come to believe that all the important knowledge already lies within itself.

So we wanted a vehicle that could "import" ideas from other places, other sectors, other times – something a person could read, if she wished, as a kind of travelogue in those few minutes between the budget meeting and the staff orientation session.

Needless to say, we bring a few beliefs to *Import*. Here are the main ones:

- We believe human service systems are, at their root, moral and ethical. They are technologized but they should not be over-technologized to the point of obscuring the values underneath the techniques. We should be just as interested in "best values" as we are in best practices.
- We cannot pretend the rest of the world doesn't matter. It is not in our narrow best interest to hold to this pretense. Herman Melville in *Moby Dick* put it better than I can, in his description of Queequeg, the pagan harpooner aboard the whaling ship Pequod:

> *"He [Queequeg, after saving a fellow sailor from drowning] did not seem to think at all that he deserved a medal from the Humane and Magnanimous Societies. He only asked for*

> *water – fresh water – something to wipe the brine off; that done, he put on dry clothes, lighted his pipe, and leaning against the bulwarks, and mildly eyeing those around him, seemed to be saying to himself – 'It's a mutual, joint-stock world, in all meridians. We cannibals must help these Christians."*

We hope *Import* reflects the best and the worst of what takes place in our joint-stock world, as we all struggle to understand that the death of a child in Calcutta impoverishes our joint humanity as much as the death of a child in Belleville.

- We believe the civic sector – that array of community organizations, faith communities and other communities of interest that help make up a civil society – is a fitting partner with government and the private sector in assuring our wellbeing. But it should not be the servant of government or the private sector. To steal from a nursery rhyme, when government and private enterprise are good they are very very good, and when they are bad they are horrid. We also believe the civic sector has its own flaws – its tendency to be balkanized and self-defeating on occasion, and too willing to accept the servant role. But it is a necessary bulwark against the possibility of sledgehammer governments and rampant vacuous free markets.
- We believe the roots of our wellbeing run deeper than our traditional helping systems. We believe in a strong health care system, for instance, but a society can become so health-care obsessed that it looses track of the need to understand and invest in the things that determine health and wellbeing in the first place.
- We believe, sentimentally perhaps, in the power of heroes – the people in Windsor, Moose Jaw, Johannesburg or Kuala Lumpur who buck the prevailing reward systems offered by their societies, who are compelled to do what is right rather than what is conventional. Heroes can be intensely annoying in person (Emerson said *"there is somewhat not holy"* in heroes), but they are society's outriders – moral scouts who ride where most of us are not ready to go. May there be more of them.

Another point before we end this introspective look at our first few years. Some readers and friends have suggested (with kindness) that we are too critical of what happens in the US. Perhaps they are right. But our criticism is not directed at Americans or at their system – a system that for two hundred years has shown a remarkable capacity for self-correction. If I couldn't live in Canada I would far sooner live in the US than in Zimbabwe or Belarus or Bolivia.

But what the United States chooses to do is intimately linked these days with the wellbeing of everyone everywhere.

Nine months after we started writing our newsletter, the World Trade Center obscenity took place. Since then many, but by no means all, Americans have applauded policies designed to perpetuate and worsen injustices in their homeland and to alienate the rest of the world – policies that have undermined the health and wellbeing of millions of global citizens. But we believe (or we hope) that America's innate yearning for justice will prevail – the yearning that fuelled Martin Luther King Jr., Sojourner Truth, Saul Alinsky, Mother Bickerdyke, Cesar Chavez and Betty Friedan. May that yearning, turned into action, move America (and thereby all of us) back from the brink.

I have used the pronoun "we" several times in this editorial. The other half of the "we" is Floyd Dale, Principal of the consulting firm Dale Associates. A social worker by trade and former Executive Director of the Cochrane and Simcoe County District Health Councils, Floyd is a partner in much of the consulting work carried out by The Agora Group. He makes sure each edition of *Import* looks pretty, and he understands the arcana of conversions to PDF files. More importantly, he edits me when I am too obscure, too strident, or just plain silly.

And a thank you to Michael Moralis – formerly of Toronto, now of California – who said to me over three years ago, *"You talk and think too much. You should write a newsletter"*.

John Butler, The Agora Group

## FROM THE QUOTES VAULT

*"All big changes in human history have been arrived at slowly and through many compromises."*

Eleanor Roosevelt

*"If Americans become a truly insular people, suspicious of the world and of its motives, the nation is likely to head down unsavory paths, to an empire bereft of the values that give the United States a legitimate claim to leadership. In the end, in that event, it will become an empire that will have drifted from its bedrock moorings and it will fail. The better road would have Americans undertake their responsibility to genuinely engage the world they purport to lead, building relationships that will both facilitate the restoration of imperial order and soften the resentments that breed chaos. There is no guarantee that such an empire will succeed – history has no precedent – but in the effort Americans will have put behind them the rubble of 9/11, returning to the path upon which they were embarked, while remaining true to themselves."*

Juan A. Alsace, *In Search of Monsters to Destroy: American Empire in the New Millennium*, published in the Autumn 2003 edition of *Parameters* (the US Army War College quarterly journal). See http://carlisle-www.army.mil/usawc/Parameters/03autumn/alsace.htm.