

The Pulse

Newsletter

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15 Gervais Drive, Suite 305, Toronto, Ontario M3C 1Y8 tel: 416-441-2502 fax: 416-441-4073 ohc@sympatico.ca www.ontariohealthcoalition.ca

Rural and Northern Health Panel A Sham, Unless Terms of Reference are Changed and Public Consultations Held

By Aisha Brown, Campaign Director

On October 15th, three months after the announcement of its Rural and Northern Health Panel, the McGuinty government released the long-anticipated Terms of Reference that will guide this panel. Panel members were officially announced months ago, on June 28th. The panel was created in response to rally organized by the Ontario Health Coalition and dozens of municipalities last spring at Queen’s Park, protesting hospital cuts and closures that have particularly devastated small and rural hospitals . The delayed terms of reference fail to inspire any confidence that the concerns of Ontarians living in rural and northern communities will be given proper consideration.

Glaringly missing from the text of the panel’s terms of reference is any single mention of the word “hospital”, even though the panel was announced in response to massive protest over small and rural hospital cuts. In fact, the terms of reference are full of relatively meaningless buzzwords; according to the Ministry of Health website:

“the mandate of the panel will be to identify a vision, strategic directions and principles to assist Government and LHINs in ensuring access to care as one of several dimensions of improving quality of care in rural, remote and northern communities.”

There are no plans for public consultations until after the panel has completed its work this winter. The panel itself will not be conducting any public consultations. Thus, it is not the independent third party review of the government’s policy of closing small and rural hospitals as the Minister intimated.

The panel only intends to meet once per month until January when it will report to the Minister (no word yet on whether or not that report will be made public). Therefore the same bureaucrats that have fomented the policy of closing small and rural hospitals will control the process.

continued p 3 >



Eva Davis, Mark Rediger and Patti Chmelyk from the Brampton Health Coalition, spent a weekend at the St. Lawrence Market in Toronto selling garlic and cards for the Ontario Health Coalition fundraising.

Eva Davis celebrated her 90th birthday last September. She is a long time member and supporter of the Brampton and Ontario Health Coalitions. Eva is always willing to help in any way she can. In the past she has volunteered in St. Catharines and Woodstock with plebiscites held to stop the P3 hospitals planned for those communities. Eva has spent many evenings going door-to-door in Brampton when we were raising awareness of the P3 hospital planned here.

Dora Jeffries, co chair Ontario Health Coalition

In This Issue

- Rural & Northern Health Panel Sham..... pp 1
- Restructuring or Deregulation?
Ontario Long Term Care Homes..... pp 2
- Quick Updates: Hospitals, Homecare.....pp 4
- OHC 2009-10 Action Plan.....pp 4
- Medicare on Trial: Brian Day's Private Surgical
Hospital in Court with B.C. Government..pp 5
- Updates from Across Canada on National Medicare
Week.....pp 6
- Battle Over Health Reform in U.S..... pp 7

Ontario

Transformation or Deregulation?

Ontario's Plans for Long Term Care Homes Carry Some Promise, but also Major Problems

In September, the McGuinty government released its second set of draft regulations under the new Long Term Care Homes Act. The first set of draft regulations were released in the spring. Both sets of regulations were subject to a 30-day consultation period, in which organizations could send in written responses. The Act will not be in force until regulations are passed by cabinet. The new regulations set out specifics for the legislation and will replace the entire Facility Program Manual once they are passed into effect.

The regulatory process is one plank in a "transformation" agenda for long term care homes. The others include the implementation of the Shirlee Sharkey recommendations, the adoption across the province of the new resident assessment system, and new rules for the inspectors (compliance and enforcement regime).

This transformation carries with it some promise for improvement, and several major problems.

First, the potential for major improvement in inspections:

According to information provided in government meetings with a few select stakeholders, the new inspection regime will enable inspectors to interview random samples of residents and front-line staff in long term care homes. The Ontario Health Coalition has long advocated that inspectors be empowered to talk with residents, family members and front-line staff, not just administrators. It is not clear, however, whether inspectors will be mandated to interview families also, something that is crucial given the high rate of

dementia and the fear of reprisal among residents.

The problems:

The new regulatory regime, according to the draft documents released so far, contains major and serious deregulation of both staffing standards and requirements for programs and services. This is the *opposite* of the "revolution" promised by former Health Minister George Smitherman.

- There is no minimum care standard. We advocated for a minimum, based on the best international evidence, of 3.5 hours per resident per day of hands-on nursing and personal care. This minimum would be an average, going up for homes with relatively higher care needs and down for those with relatively lower care needs. The McGuinty government amended the legislation to provide for a regulated care standard. However, Shirlee Sharkey opposed (based on a misreading of the evidence and a seriously flawed report). There is no minimum care standard in the new draft regulations, and even the minimal requirement that homes have enough staff to provide for the assessed needs of the residents - as per the former regulations under the Nursing Homes Act - has been removed.
- The new long term care homes legislation provided opportunity for regulations to be passed to provide for standards and criteria and outcome measures for the

programs and services of the homes. But there are few standards, only some criteria, and no outcome measures. This is of grave concern. It is not clear how compliance officers (inspectors) can issue orders without these, nor whether these orders could be enforced without these and without a requirement for enough staffing to do so.

- In the vital areas of Required Programs and Services, former standards that were required (and therefore inspected and subject to compliance regime) have been removed. Required services that were in the Program Manual have been dropped. In these, and other significant areas, these draft regulations are significantly less than what has been in place to date, despite promises by the McGuinty government for a "revolution" that would improve care in our nursing homes.
- The legislation requires homes to limit the use of agency (temp) staff. However, the regulations allow wider use of agency staff, and the training requirements do not clearly require that such temporary staff be familiar with the residents' needs. This is a critical continuity of care and quality of care issue. Further, it seems improper that the regulations can counter the direction of the legislation which has been passed in the legislature.
- The regulations must clearly prohibit the use of retirement homes as de facto unregulated private for-profit

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Rural and Northern Health Panel cont'd from page 1...

In early November, the OHC, along with several municipal leaders and member organizations, called a string of press conferences in areas where hospital services are in serious jeopardy. Our key demands are:

1. The Panel must review of the impact of rural hospital cuts and closures on the affected communities.
2. The government must impose a moratorium on cuts and closures, in keeping with the recommendation for a moratorium made by the Ontario Medical Association.
3. The panel must hold cross-province public consultations, on the record, with the opportunity for residents to bring their concerns forward.

At a November 3rd press conference in Newbury, Panel appointee Mayor Doug Reycraft of Southwest Middlesex, refuted our claim that the panel currently has no plans to hold public consultations, stating that community members have the option of providing their input to the panel by means of an internet link. Since there is no broadband internet in

this area, he told people to go to the library to access the internet!

We tried it. At first, we could not find a place to provide feedback, even if people could find "rural and northern health panel". When we eventually found it, the link in question goes to a generic "Service Ontario" email. There is no indication that panel members will ever see your input. The internet link requests that you answer to five pointed questions, it does not allow for submissions.



Representatives from Burk's Falls coalition, including Mayor Cathy Still attended Question Period at the Ontario Legislature in October, where they delivered 6,700 signatures on petitions to save the hospital.

Attempts to meet with panel members by local groups have been stymied. Calls have been returned by the Health Minister's office, not the panelists. Other panelists have told the groups that they have had to sign confidentiality statements and they cannot meet.

This is not public consultation. It is a heavily controlled process with almost no meaningful chance for the public – who pay for and rely on our local hospitals - to have any input. Please contact your MPP to insist on points 1 - 3 above and tell them what you think.

Long Term Care cont'd from page 2...

long term care homes. They are not recognized as health facilities under any legislation. They are not regulated. They do not provide any standard of care. It is not in the public interest to create a second tier of unregulated privatized long term care homes that are really retirement homes.

- There is nothing in the regulations to prevent the continued downloading of heavy-care patients from hospitals and mental health facilities into long term care homes that lack adequate staff and training to deal with the complexity of these patients' requirements.
- There is no requirement that homes keep refusal lists to ascertain if there is a pattern of discrimination against certain classes of disability or care need. There is no ability for a person refused admission to appeal to the Health Services Appeal Board.

- There is no regulation pertaining to abuse or neglect perpetrated by the home owner, nor any party except for staff. There is no definition of "zero tolerance".
- Key recommendations from the Casa Verde inquest into the homicides of two residents at the hands of a resident with dementia have been ignored. These include recommendations for care plans to be developed prior to admission, with full communication, and clear staffing standards to provide adequate care for residents with behavioural issues.
- There are no definitions and no criteria for "rights advisors" and "secure units". This is crucial. Residents must have rights and an effective advocacy system to prevent forced confinement except under specified circumstances.

The OHC has provided full analysis and synopsis of both sets of draft regulations on our website. Go to www.ontariohealthcoalition.ca and click on "long term care" in the left hand column to download them or call/email the office and we will send you copies.

Upcoming in the OHC strategy for Long Term Care Homes:

A new analysis of the Shirlee Sharkey approach to LTC transformation from internationally-renowned experts

- New fact sheets on:
- The new resident assessment system
 - ALC (Alternate Level of Care) - what it means for patients
 - The new compliance regime
 - LTC funding - how it works and how it is being changed

Lobby Training Session - we will announce the date shortly

High-level briefing and strategy session to be held early next year

Ontario

Health Coalition Adopts Ambitious Action Plan for 2009-10

On Saturday October 17th 2009, the Ontario Health Coalition and its members met to discuss and finalize our 2009-2010 Action Plan. The following is a summary of the initiatives that have been approved by both the OHC board and our members. For a copy of the action plan including a listing of specific initiatives from each sector, please call or email us. Phone 416-441-2502 or email ohc@sympatico.ca

Hospitals

In order to address inadequate funding and significant cuts to hospital services over the last two years, and in response to inadequate increases planned for the upcoming year, we will focus our campaign on making these cuts a major policy issue. We approved an escalating cross-province action plan including hearings, town halls, summits, local campaigns and protests.

Privatization

A significant portion of for-profit privatization has occurred by stealth. We plan to measure and expose the significant increase of for-profit privatization in health care by creating an annual report on privatization. In addition to the status of privatization, the report should include information about market consolidation and analysis of the problems created by privatization.

Privatized P3 Hospitals

After successfully decreasing the amount of P3 projects and scope of privatization in the P3 hospital projects planned for Ontario by exposing the overspending and poor results of Brampton's P3, we will renew our campaign to stop the renewal of expensive and damaging privatized P3 hospital contracts. We are currently waiting for the government to fill information requests on current P3 projects including Woodstock, Niagara, Bridgepoint and others. We will seek financial review and will be conducting a community campaign in Niagara.

Long Term Care Homes

By holding two mini-conferences on long term care homes recently, involving family councils, residents' councils, unions, health professionals, seniors' groups and local health coalitions, we have forged a renewed consensus on the main priorities for reform, including a minimum care standard and public access to information. We will be undertaking an escalating lobby and protest campaign to stop the deregulation of the sector and win improvements to care and standards.

Homecare

To improve conditions for patients and staff in homecare, and to achieve parity across the homecare, nursing home and hospital sectors, we will fight the reintroduction of competitive bidding and we will advocate for the ability to for the elderly to age in place. If competitive bidding is re-introduced, watch for mass protests!

Other Initiatives Include:

- An action plan to protect and re-instate **democratic hospital boards**
- An action plan for **democracy/public accountability** (including access to information at the Ministry of Health and Long Term Care)
- The expansion and development of **Students for Medicare**
- Setting up a **primary health care** committee
- Work to ensure stopping privatization is a **federal election** issue



Panel discusses lessons from hospital restructuring fight-back at OHC Assembly in late October. Left to right: Helen Havlik from the Sarnia Lambton Health Coalition; Sue Hotte from the Niagara Health Coalition; Natalie Mehra OHC Director; Dora Jeffries OHC chair, Doug Allan OHC Board member.

Quick Updates

Raising the Profile of Homecare

We Need to Hear Your Stories

The government is moving forward with revising the Requests for Proposals and the reintroduction of competitive bidding in homecare, planned for 2010. The OHC is participating in two initiatives with the goal of improving the profile of this important health sector.

1. In January, the coalition will be working with CUPE to release a new homecare video across Ontario.
2. The coalition is working with two investigative journalists and SEIU to collect homecare stories. Please contact us if you have had an experience with homecare in Ontario in recent years. Email: ohc@sympatico.ca or call 416-441-2502.

Hospital Cuts Fight-Back Campaigns

We are working with local coalitions to release 1-800 lines to collect stories from people trying to access hospital services. So far, hotlines have been established in: Niagara - call 1-888-309-2008
Sarnia-Lambton - call 1-877-542-1895
Wallaceburg - call 1-877-363-6767

Local groups are continuing the fight-back with town hall meetings, petition campaigns, complaints to the ombudsman, protests and mass-leafletting.

Canada

Medicare On Trial: B.C. Government, Patients and "Dr. Profit" Brian Day Face Off in the B.C. Supreme Court

by Natalie Mehra, Director

On November 17, the BC Supreme Court ruled that the B.C. government could audit Dr. Brian Day's private for-profit surgical hospitals, something Day had been fighting for almost a year.

The court also ruled that a case by a for-profit health care lobby group challenging the constitutionality of public medicare would be heard in the B.C. Supreme Court. Brian Day sits on the board of the lobby group along with William Oravan (involved in the attempt to bring in private surgeries in Ontario in the last election), Don Copeman (of the private physician clinics charging patients thousands of dollars in "membership fees" that we stopped in Ontario), Mark Godley of the False Creek private clinics and a host of other for-profit clinic owners. Day was nicknamed "Dr. Profit" by the Council of Canadians.

Day has admitted that his private hospitals' billing practices are in violation to B.C.'s Medicare Protection Act. The clinics charge the public health plan and also extra-bill patients thousands of dollars for the same procedures in what they call "facility fees".

In a sworn affidavit dated July 23, Bob DeFaye, the chair of the Medical Services Commission of the B.C. government, alleged, "When the Commission made its decision to audit the clinics, it was aware of correspondence from approximately 30 individuals, from which it concluded that the clinics, either individually or together, had charged beneficiaries for medically required service in contravention of the Act."

The B.C. Health Coalition, Canadian Doctors for Medicare, two doctors

and two patients have been granted "intervener status" in the court proceedings and will be arguing for the protection of single-tier medicare and the improvement to access to care in the public system.

The audits of Day's for-profit operations will begin this March. They are the culmination of a year of court actions and the beginning of a Supreme Court challenge that holds significant consequences for the future of Public Medicare across Canada.



In December 2008, patients took the B.C. government to court arguing that the province's for-profit clinics were regularly charging unlawful user-fees and extra-billing patients for procedures that should be covered under the public health system. They demanded that the B.C. government enforce their Medicare Protection Act and protect patients against the billing practices of the clinics that are posing a threat to single-tier health care.

Last January, the private clinics responded with a lawsuit of their own. Day's private hospital corporation and the private clinics' lobby launched their case claiming that the public medicare system is unconstitutional. Day's hospitals refused access to government auditors looking into extra-billing complaints by patients, and asked the

court to refuse the government the right to audit their operations. The court ruled in favour of the government audits, but is also going to hear the constitutional challenge to medicare.

In a major report, written by the Ontario Health Coalition and sponsored by Health Coalitions across Canada in 2008, we found 89 violations of the Canada Health Act in 5 provinces. In British Columbia, we found 29 clinics that we suspect are violating the Act's prohibition of extra-billing, user fees for patients and queue-jumping. Prices were exorbitant; far above the reach of most B.C. residents whose average annual income according to Statistics Canada was \$24,000 in 2005. Partial knee replacements were being sold for \$13-20,000 and MRI prices ranged from \$500 - \$2,200.

The patients who started the first lawsuit have told the press that they took the government to court to enforce single-tier medicare because they are concerned that B.C. patients are being denied access to care based on their wealth, not medical need. Watch for next steps after the B.C. government has audited the clinics and completed its investigation into their billing practices.

What is certain is that the stakes - for all Canadians - are high. As Leslie Dickout of the B.C. Health Coalition described Day's court challenge to The Tyee (independent online news source in B.C.), "This lawsuit threatens Canadians' ability to access affordable health care when they need it. It threatens the principles of equality and fairness that are fundamental to our Canadian health care system."

Note: cartoon reprinted with permission from Artisans.com

Canada

Cross Canada Check In

Victory in New Brunswick: Private MRI Clinic Stopped

After New Brunswick's Health Minister called for privatization of the province's health system, the Canadian Health Coalition and provincial activists went to work. Three large town hall meetings were held, a letter-writing campaign was launched, and trainers trained to present to community groups about the value of public versus privatized health care. Their efforts have succeeded. Two months ago, the New Brunswick premier decided to refuse a private diagnostic imaging company a \$60 million contract. The Health Minister was replaced by a more moderate minister. Congratulations to the community activists, local unions and the Canadian Health Coalition!

Health Centralization a Major Issue in Newfoundland By-Elections

Premier Danny Williams has remained supportive of public health care throughout his term in office. But in recent months, attempts by his government to pull x-ray and other services out of local districts resulted in the loss of two seats for his government. At a recent meeting of the Canadian Health Coalition, chair (and Newfoundland resident) Kathleen Connors noted of one of the by-elections, "The premier and nine cabinet ministers spent all kinds of time there and they still lost the seat." The message - that health care services are a crucial voting issue - was heard loud and clear. Congratulations to the NFLD Health Coalition.

Alberta Facing Major Health Restructuring

The Alberta government is moving ahead with the consolidation of 9 health regions into one super-region, administered by an economist from Australia. Meanwhile, the conservative government has plummeted in the polls - from 51% - 34% support - and health care remains the top issue for voters. The government has tried to move ahead with deeply unpopular closures of small and rural hospitals. It is divesting itself of responsibility for seniors in long term care, closing hundreds of long term care beds. In Fort McMurray, the conservative MLA opposed the closure of the local long term care home and was expelled from the party as a result. 28,000 Albertans have signed petitions, and the provincial coalition - Friends of Medicare - is growing, organizing local chapters and mounting an aggressive campaign. Look on YouTube for their recent videos.



Privatized, For-Profit Health Care:
Pay More and Get Less

Sign the Medicare Pledge

Medicare Pledge

As a Canadian, I believe access to quality health care must be based on need, not ability to pay.

Our public health care reflects those values of equality and fairness.

We must improve our public health care for everyone, instead of expanding private for-profit services that benefit only a few.

I pledge my support for the protection and improvement of public health care in Canada.

Full Name _____ Email Address _____

City/Town _____ Province _____

Add my name to the Canadian Health Coalition contact list? (Circle one) YES NO

Return to: Canadian Health Coalition, 2841 Riverside Drive, Ontario K1V 8X7

Note: the OHC is a provincial coalition with our own board and membership list. This pledge is by the Canadian Health Coalition. We are affiliated to the Canadian Health Coalition and support each others' work.

The U.S. Healthcare Debate

Spinning Fiction into Public Opinion:

U.S. Opponents of Health Reform Are Making a Sport of Maligning Canada's Health System *Health Coalition Volunteer John Kneeland Takes a Closer Look at the Facts*

by John Kneeland

The health care debate in the United States is heating up. In the face of virulent Republican opposition, Democrats have obtained the 60 votes necessary in the Senate to begin debate on the Senate health care reform bill. Republican ads are now targeting moderate Democrats who agreed to support debate on the bill.

A version of the bill passed by the House of Representatives has already been assessed by the Congressional Budget Office, which stated that it "would yield a net reduction in federal budget deficits of \$109 billion over the 2010-2019 period." The CBO, which doesn't normally do projections for periods of over 10 years, cautions, "In the subsequent decade, the collective effect of its provisions would probably be slight reductions in federal budget deficits. Those estimates are all subject to substantial uncertainty."

The Committee for a Responsible Federal Budget, whose members include past directors of budget committees, the CBO, and the Federal Reserve Board, has also examined the bill, and is very careful in its assessment. "Done wisely," says CRFB, "health care reform could considerably slow economy-wide health care cost." But done poorly, says the organization, reform could exacerbate costs. The CRFB believes that in general, none of the bills go far enough in recommending strong measures to reduce the severe deficit picture in the United States.

All these are irrelevant niceties to Republicans, who have come not to praise health care reform, but to bury it. Soon after the Democratic victory in the Senate, Republican Mitch McConnell, Senate Minority Leader, appeared on CNN and claimed that the bill would

bankrupt businesses, raise everyone's premiums, and add almost a trillion dollars to the deficit.

When asked for their own health reform plan, Republicans typically respond with talk about capping lawsuits, despite the fact that the cost of malpractice suits represents less than half a percent of U.S. health care spending. Still, in fear of suits, American doctors pay huge sums to for-profit firms for health insurance. For example, a neurosurgeon in Miami pays \$237,000 per year. Yet malpractice insurance for neurosurgeons in Canada ranges from a little over \$10,000 per year to just under \$30,000. This is because Canadian doctors receive blanket coverage through the non-profit Canadian Medical Protective Association, which also pays damages, no matter how much. All physicians in each category pay the same amount for insurance, regardless of how many claims have been filed against any one doctor.

While American doctors accumulate hundreds of thousands of dollars of debt to pay for a medical education, the schooling of Canadian doctors is mostly government-subsidized. Add to this the fact that, as a doctor in Florida once told me, any American physician typically has to deal with filling out paperwork for about 250 different HMOs, and it makes sense that many Canadian doctors choose to stay here to practice, regardless of the lure of big money in the U.S.

Nonetheless, it's a no-brainer that the American opposition to health reform, often major recipients of health insurance industry largesse, will continue to use Canada as an example of the terrifying spectre of government-run healthcare. And they are more than willing to stretch the

truth to do it.

At the height of the Town Hall meetings on health care reform, Tom Coburn, Republican Junior Senator from Oklahoma, was asked by a questioner why he had such a problem with the idea of public healthcare. Coburn replied that he could give a good example of what's wrong with public healthcare: Canada. Death rates from cancer of all types, he said, were 30% higher in Canada than in the United States.

I guess Coburn, a physician, forgot to read the 2007 comprehensive review of Canadian and U.S. studies on health outcomes published in the peer-reviewed journal *Open Medicine*. This study found that outcomes were better in Canada. A study reported on by *Health Affairs* in 2008 ranked 19 industrialized nations by the percentage of patients who survive serious but treatable illnesses, both in 1997-1998 and 2002-2003. In those years, Canada moved from seventh to sixth on the list. The United States, originally ranked sixteenth, now plods along in last place.

In a 2008 Health Canada study, patients self-reported median wait times for MRIs and CAT scans of two weeks. Median wait time for a specialist or surgery was a little over four weeks. Most patients waited a maximum of three months.

Similar results were reported by Dr. David Zelt, Chief of Staff at Kingston General Hospital, an institution which, ironically, Mitch McConnell used in a speech on the Senate floor about the problems with Canadian health care.

In McConnell's hands, the wait time

continued on next page....

The Debate in the U.S. cont'd from page 7...

of 32 days for cardiac surgery at KGH was magically transformed into six months. Wait times for all cancers, McConnell maintained, were upwards of three months. In reality, the waiting period at KGH is eight days for neurosurgical cancer, 16 days for breast cancer, and 49 days for prostate cancer. McConnell inflated the wait of 109 days for knee replacement surgery into 340 days.

Zelt considered McConnell's exaggerations so egregious that he sent him a letter in which he stated, "You have maligned a very proud institution whose service to our community dates back some 170 years." Tory Senator Hugh Segal rebuked McConnell on the floor of the Canadian Senate, and noted that the expected life span in Kentucky, McConnell's home state, is 75.2 years, while in Kingston, it is 78.3 years.

McConnell was one of the Republicans who attempted to make political hay out of the Shona Holmes case. Holmes, from Waterdown, Ontario, appeared in a series of ads sponsored by Citizens United Now, claiming that she had been forced to go to the United States to have a brain tumor treated. She said that she was unable to obtain treatment in Canada, where, she said, healthcare "certainly isn't free."

Holmes was invited to testify before the House Energy and Commerce Committee, to whom she said, "If I had relied on my own government-run health care system in Canada, I would not be sitting here before you today. At the very best, I would be blind and the very worst I would be dead."

In a subsequent appearance on Fox News, Holmes told the interviewer that her American friends advised getting another doctor. She then falsely claimed, "that is something we

are just not allowed to do here in Canada."

Dr. Rolando Del Maestro, director of the brain tumour research centre at the Montreal Neurological Institute, calls Holmes' claim "an exaggeration." He says the lesion Holmes was diagnosed with, a Rathke's cleft cyst, is benign, and usually slow-growing. It typically does not require urgent attention, he said. He adds, "If it's a real emergency in the sense that the patient's visual function is getting substantially worse, the patients would be brought in immediately and would be operated on the next day."

Neurosurgeon Michael Schwartz of Toronto's Sunnybrook Hospital says he's never seen or heard of a death from a Rathke's cyst. He told CBC News that the cyst can be drained or partially removed to take pressure off the optic nerve. "Then the person's vision almost always improves," he says, and the symptoms disappear.

Holmes paid almost \$100,000 to have the cyst removed at the Mayo clinic in Arizona. Even Fredric Meyer, M.D., chair of neurosurgery at Mayo Clinic in Rochester, Minn., says that "RCC is a benign lesion and is not typically life-threatening."

The group that paid for the Shona Holmes ads, Citizens United Now, is an offshoot of Americans for Prosperity, one of the groups behind Tea Party Protests in the United States. Americans for Prosperity is funded by the Koch Family of Foundations, and was founded by David Koch, a descendant of ultra-conservative oil baron Charles Koch.

While disavowing Canadian health care, Holmes was still enough of a believer in government-funded medicine to demand reimbursement from OHIP for her expenses. When she was refused, Holmes filed suit, claiming that Ontario had violated her Charter right to timely medical

care. Her suit is being funded by the Canadian Constitution Foundation, a conservative pro-business organization closely linked to the Fraser Institute. The CCF is mounting a campaign to bring privatization to Canada.

Those who criticize Canada's system should be aware that U.S. citizens who can't afford ongoing medical treatment and don't qualify for Medicare or Medicaid simply have no recourse. Over forty thousand deaths per year occur in the United States among them.

Many American doctors believe that a single-payer system similar to Canada's is the only practical solution to their problems. They look to our system as a model of humane and efficient delivery of care. It's something that we shouldn't take for granted.



New! Reports, Publications, Fact Sheets and Videos

Go to www.ontariohealthcoalition.ca

Upcoming: look for new fact sheets on key issues in Long Term Care

New on the website: videos and slide shows of the campaign to save ospitals.

Presentation by economist Hugh Mackenzie on health care spending and sustainability from our October Health Action Assembly.

New press release on laboratory privatization.

OHC Response to Draft Long Term Care Regulations (Parts I & II)