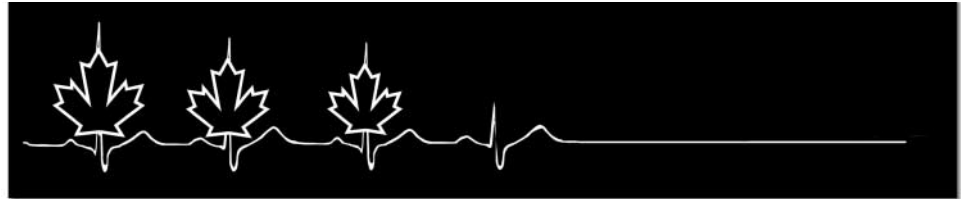


CANADIAN TREATMENT ACTION COUNCIL



BAD MEDICINE:



INSIDE JUNE 2002 VOLUME 4 ISSUE 2

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Health Care Reform and What You Can Do About It

by Tony Di Pede

The public health care system we rely on is in danger. Governments have been studying ways to “reform” it. The latest in a long list of federal and provincial groups examining it is the Romanow Commission. What governments really appear to be studying is a way to reduce their responsibility to finance health care, thereby abdicating responsibility to ensure Canadians’ access to needed health care.

The principles of our public health care system are directed by the *Canada Health Act (CHA)* which is a federal law. Provincial governments decide delivery methods of health care services. Provinces agree to follow the CHA in exchange for federal government funding. The CHA requires provinces to maintain the principles of: public administration (the government pays and manages); portability (access anywhere in Canada), universality (all citizens qualify); and comprehensiveness (include all medically necessary hospital and physician services). CTAC believes these principles of the CHA should not be changed to allow “reforms” to be enacted.

Most of the “reforms” being suggested attempt to shift the costs of health care from government to individual users of health care, such as people living with HIV/AIDS. The result will be that only those who can afford to pay will get the quality health care they need. A few of the most troubling reforms being suggested are:

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BAD MEDICINE

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User Fees:

Every time you go to the doctor, hospital or get a test you will have to pay a fee, either a flat fee or a percentage of the cost.

Medical Savings Account:

The government will put an amount in a designated account for every person to be used for medical services. When the account is gone, you pay for the additional services or you purchase private health insurance to cover them.

De-listing Services:

Most medically necessary services are currently covered. De-listing will reduce the services covered. Additional services would have to be paid privately.

Privatizing Health Care:

Turning over all or parts of the health care system to business. Business may be more concerned with generating profit than providing quality health care. Money is drained from services when profits are paid to shareholders.

Allowing Private Health Care:

People would be allowed to pay privately to "move to the front of the line". Alternatively, a separate private health care system has also been suggested. This would result in a two-tier scheme, a private system for those who can pay and a public system for everyone else. Canadians could either pay directly to access the private system or purchase health insurance. The quality of the public health care system will definitely decline dramatically.

Any and all of these reforms would mean the end of universal health care for all. CTAC, along with many of other groups, strongly opposes any reforms that will restrict access to quality health care for people living with HIV/AIDS and

other Canadians. Representatives from CTAC have presented in Romanow's Public Consultations; CTAC has held news conferences across Canada and continues to meet with politicians and bureaucrats about this issue. You can help directly. Please sign and mail the postcard to the Prime Minister included in the newsletter. Go to the CTAC website www.ctac.ca for more information on Health Care Reform and learn how to have your voice heard. ■

CTAC's Annual General Meeting

CTAC's Annual General Meeting (AGM) will be held in St. John's, Nfld. October 6th-7th. All Members are entitled to participate in the AGM. Full members will receive a nominations package containing information on how to participate. If you have not received your nominations package by July 8, 2002, please contact the CTAC office.

If you are not a member of CTAC, please visit www.ctac.ca or contact the CTAC office by July 8th to become a member. Please note that new membership applications received after July 8 may not be processed in time for participation in the 2002 AGM and Elections. Membership in CTAC is free and CTAC's membership list is confidential. ■

Sooner or later everybody has to go to the doctor. Personally, I probably have to go more often than most, since with HIV, I need regular check-ups, blood work, medication changes and all the rest.

I've been seeing the same doctor for years. To make an appointment I just phone up his clinic. I can usually see him within a week. If something seems urgent, I can usually get in faster.

Once I'm there, we figure out what kinds of tests I need, what kinds of drugs. Maybe he'll refer me to a specialist. It's straightforward, convenient, simple, and means I can get the kind of medical care I need, when I need it.

A friend of mine in the States is also HIV positive. He changed jobs a couple of years ago. A new company meant a different insurance plan and a new health management organization so he had to change doctors. Now, because of the recession, he got laid off. He soon may not be able to go to the doctor at all, unless he can pay for it. Which is hard when you're laid off. So every time I talk to him I find myself thanking my lucky stars that I live in a country with public, comprehensive, universal health care.

For the time being anyway. Because certain people want to change all that. The right-wing press has been howling for years that there is a crisis in our medical system. They say we can't afford it. They say there are line-ups. They say we need to be more like the Americans and people should have the right to jump the queue and pay to go to the doctor. They say we've got to change.

Most Canadians disagree. In survey after survey we consistently rate our medical system highly and want to preserve it.

That's not to say that our medical system isn't under stress. It is. It's short of money — for two main reasons.

Sooner Sooner or later later

A perspective on Health Care Reform

by *Tim McCaskell*

Originally printed in *Xtra*, April 18, 2002

The first is that in order to deliver big tax cuts to its corporate sponsors while reducing the deficit, the federal government has drastically reduced the money it used to give to the provinces to provide health care. The second is that the feds also changed the patent laws about ten years ago to allow their buddies in the pharmaceutical industry patent protection for up to twenty years. That meant drug companies could continue to charge inflated prices for a lot longer. So while the government is providing less money they've let the costs go through the roof.

Of course the Harris government here in Ontario has made things even worse. It gave even bigger tax cuts to its corporate friends. It closed dozens of hospitals causing serious back-logs in service. To solve the mess they've created they're proposing to hand over the health care "business" to American companies who will provide service at a profit. They are trying to sell the public on the idea that we will somehow get better and cheaper health care by allowing these companies to skim off millions of dollars in profit to pay their American CEOs and shareholders. Right. As if.

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Sooner or Later

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So for the last few years we have been deluged with reports full of ideas on health care "reform." A few months ago Mazankowski came up with his made-in-Alberta solution; user fees, service limitations, privatization. Now Romanow is touring the country to get people's ideas on "reform," and reports are he likes the idea of user fees and service limitations as well.

So what will it mean for us, especially those of us with HIV, if these "reformers" get their way and replace our public, universal system with a private, two-tiered one? Different "reformers" have different schemes but here's how things might look.

First, when I want to go to the doctor, there will be no more simply phoning up and making an appointment. I'll have to be screened. Someone else will decide if I really need to see him or if a nurse wouldn't do. If I insist on seeing a doctor then I'll have to pay.

Second, it will take a lot longer to get an appointment. Everywhere where two-tier private medical care has been introduced, doctors have left the public system to earn big bucks in the private sector, meaning fewer doctors and longer waits for those of us without bags of money to spend.

Third, even if the screening process determines that I do need to see a doc, and I can survive the wait, I may have to pay a "user fee" anyway. The "reformers" say this will discourage abuse. As if people enjoy going to the doctor as a cheap form of entertainment.

Fourth, after I've jumped all these hurdles and paid my fee, my doctor may not be able to order the tests or prescribe the meds, or refer me to the specialist that he thinks I need, because all of these things will be tightly regulated, rationed out, or "delisted" in the public system. Some of that is already happening.

Finally some of the "reformers" are proposing that we pay doctors to treat a given number of patients. It's called "capitation." In that case my doctor may decide he doesn't want me as a patient at all, since he can make more money seeing a lot of relatively healthy people with an occasional cold or flu than he can treating somebody with a complicated, chronic illness like mine.

These "reforms" are being sold to the rich and powerful by promising them that they'll be able to get faster, better medical care by paying for it and not having to wait in line with the rest of us. Ironically it will probably make things worse for them too. With most people relying on an even more under funded, understaffed public system, there will be a lot more people who are sicker wandering around. That's guaranteed to produce public health disasters like the new American TB epidemic. When public health declines, everybody's health suffers.

Public health "reform" is certainly not good for me. And unless you're Bill Gates, it's probably not going to be good for most people. And like I said, sooner or later everybody has to go to the doctor.

So as far as I'm concerned it's time to tell the privatizers that they can stick their "reforms" where the sun don't shine. A publicly funded, universal, health care system is ultimately cheaper, more efficient and better for everybody's health. Health care is a right, not a business. We need to keep it that way. ■

A Question of Values; The Value of Questions

by Daryn Bond

Roy Romanow often says our 'values' (fundamental principles and beliefs) are central to the health care debate. Most people believe that the poor, those in need, and people with 'catastrophic illness' like HIV, should have access to medically necessary services, and illness should not lead to bankruptcy, but opinions vary widely on what is 'necessary' and how much, if any, a person should be required to pay. When it comes to the 'health care crisis' sharp differences of opinion begin to emerge. Romanow has organized these into 4 main categories:

1. More public investment – through higher taxes or cuts in other areas.
2. Share costs and responsibilities – co-payments, user fees, expanded private insurance.
3. Increase private choice – allow people to buy health care services from private clinics (i.e. care for those who can afford it – 'two-tiered').
4. Reorganize service delivery – integrate services, streamline and improve system efficiency.

Seemingly useful as a frame of reference, this approach fails to encompass all possible viewpoints and limits the discussion.

It is true that most people prefer one of the four options, but it is folly to suppose that all opinions can be captured in this way. Currently, in the *Shape the Future of Health Care in Canada Consultation Workbook*, available online and by request, Canadians are asked to rate the four categories in order of preference (e.g. 4, 1, 3, 2). To many, both 2 and 3 are equally repugnant, and while reorganization may be useful, it will fail without increased public investment. By being forced to respond in this way, data analysts can claim that people prefer user fees to two-tiered health care. Even more insidious, is that by answering the question, one is admitting that there is a crisis in the health care system. CTAC argues

that the health care debate is manufactured by government, originated through deep cuts made to provincial transfer payments, and is influenced by inefficiencies in the system. There is no way this complex position can be expressed through a simple rating exercise.

Another example from the workbook asks:

'If government determines that more public funding is essential my preference would be to:

- Pay more taxes
- Reduce funding to areas like environmental protection or education'

It is easy to see the flaw here: What about cuts to the military or airport security? How can anyone choose between the environment, education and health? Maybe you prefer higher taxes? It must be that more public investment is a bad idea. This negative question seems to suggest that many decisions have already been made and that the commission is merely looking for supportive evidence.

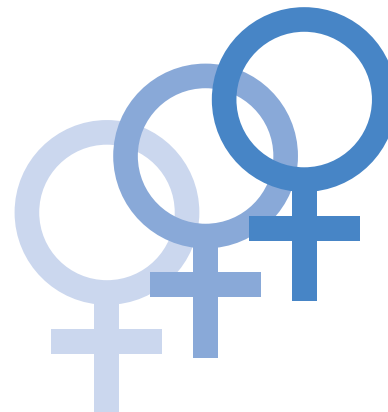
Some subjects are curiously absent from the debate. Most notably, 20 year patent protection and the effects of globalization have been excluded. Also, focus is restricted to the health care system at the expense of other factors that influence health, such as poverty, education and employment.

The value of the health care system does not seem to be in question. While most people agree with Roy Romanow that the 'house of Medicare needs remodeling and not demolishing', our values must shape this process. The debate must be open and accessible. It cannot be over-simplified and limited. Don't be fooled. Next time someone asks 'What are you willing to give up to fix the health care crisis?', consider the intent and implication of the question, smile and say, 'Health care crisis? What crisis?' ■

Women and Children First...

...to be sacrificed, that is

by Louise Binder



The old adage, “women and children first,” used to mean that society put them first. Any of you who saw the film *Titanic* know when push comes to shove, women and children are first – to be sacrificed. In addition, if you happen to be poor or otherwise marginalized, you go even farther down on the list to be looked after or protected by society.

However, Canada decided years ago that it would have as a core value of its society the basic health care of all of its citizens – rich and poor alike. Over the years, it has held on to that value, at least theoretically. On the other hand, politicians, bureaucrats and big business have worked to weaken both our belief in the practical viability of such a value and the institutions required to deliver on that promise. It has done so in numerous ways – trade agreements; drug pricing policies; health care restructuring including hospital closures; excluding home care; and limited availability of necessary drugs, to name just a few.

After having weakened the foundations of our health care system, it is moving in for the kill, so to speak. It has set up the Romanow Commission to look at the “crisis” in health care and to recommend what to do about it. Although he has not made his final report, speculation is that Romanow is seriously considering both the idea of user fees for services and a limited health care savings account for each Canadian, after which the user pays.

Who will be the biggest losers in this “reform?” Those who can least afford it – the people who actually need the system to survive – like people living with HIV/AIDS, not to mention those co-infected. Within this group,

women are even more vulnerable since their average incomes are less than men; they have a higher under and unemployment rate; they rarely have employer paid health care benefits; they are often sole parents and caregivers for their families. The government has already taken away many of their public support systems like day care and women’s shelters.

Where are women supposed to get money for user fees, either for themselves, their family members or their children? As usual, they will put themselves last and get no health care. Once they use up their health care spending account and need to see a doctor because of drug toxicities, drug interactions or opportunistic infections, they will just stop taking their drugs or get so sick they have to enter a hospital. Indeed, there will be a net saving to the system, I suppose, when women die needlessly – or when their children do.

People with HIV/AIDS are only beginning to recognize the potential disaster that health care reform may well be for us. It could take us as far back as the bad old days before treatments. Women and children may well be first – the first to go, that is. However, we will just be the canaries in the coalmine for the rest of our community and for many other Canadians. Don’t let this happen. Get involved in what threatens to be the real crisis of health care – the lack of it for those who actually need the care. ■

CTAC tells Romanow –

“Canada can and must afford health care”

by Philip Lundrigan

“Mr. Commissioner, when access to health care is diminished, people with illness suffer a diminished quality of life, and quite frankly die sooner than would be the case if adequate health care was available. I do not believe that the federal government has the right to make that decision for Canadians without a mandate to do so by either a referendum or by calling an election.

My message to you and to the people who are charged with making decisions that will affect my life is:

I don't buy the argument that we can't afford it. I believe we can and must afford it. My life depends on it. Put the money back where you found it – all of it. Remove health care from consideration at the bargaining table of any negotiations, international or otherwise, and immediately embark on measures to re-gain what has been given away and ensure that we don't give away any more. And finally, before any change is made to such a fundamental part of our society, Canadians must have their say. All options being considered and the consequences of each must be clearly spelled out for Canadians in plain language so that we, and not the politicians or bureaucrats, can make informed choices about 'The Future of Our Health Care in Canada'.”

—closing statement to the Romanow Commission by Philip Lundrigan

On April 15, 2002 I had the privilege of presenting to the Romanow Commission on behalf of CTAC at the hearings held at the Fairmont Hotel in St. John's, Nfld. The title of my presentation was “The Role of the Federal Government in Ensuring a Viable, Public and Universally Accessible Health Care System in Canada”. I outlined numerous issues and areas of concern where the Federal Government clearly has jurisdiction

such as: international trade agreements; drug patent laws; drug pricing; pan-Canadian standards of care and direct-to-consumer advertising.

Essentially, my argument was that the Federal Government, through its direct actions and through its policies and practices, has given away, shut down or blocked access to Canada's health care system. International trade agreements and domestic legislation around patents have favoured industry and resulted in increased costs and diminished access to health care.

Throughout the day of hearings in St. John's some themes emerged. Of the four options being considered by the Commission to reform the health care system, many speakers indicated that the least distasteful is re-organization of service delivery. The fundamental problem that was identified with this option is that devastating cuts to health care by the federal government have simply left us with insufficient health care resources. So, no matter how we rearrange, restructure or reorganize at the end of the day the available resources are still inadequate.

In addition, the need for more federal funding, before any other options can be considered, was consistently communicated by presenters throughout the day. Many of the speakers echoed concerns about where the proposed reforms would take us. CTAC's message resounded well with the audience.

As is the case with many other illnesses, people living with HIV/AIDS have a very intense and personal attachment to our health care system, a system which has undergone dramatic change in the past decade. A public, universal health care system is very important to CTAC and it continues to be very active in the fight to save Medicare. ■

Clinical Trials - Update



by Jim Boothroyd,
Communications Manager
at the Canadian HIV Trials Network

A popular community workshop on HIV clinical trials is coming to Ontario, Halifax and, possibly, Winnipeg, this fall.

Presented by the Canadian HIV Trials Network (CTN), a federally funded non-profit research organization, *Clinical Trials: What You Need To Know* is a full-day workshop for people with HIV/AIDS and representatives of community organizations.

The aim is to raise awareness of the importance of clinical trials in advancing treatments and to develop the skills that potential participants need to make an informed decision about whether to take part.

The plain-language workshop includes presentations and intensive work in small groups with expert facilitators. In the morning, participants focus on clinical trials: their history, purpose and design and the ethical codes that protect participants. In small groups, they also assess the risks and benefits of taking part in trials and learn about Canadian trials enrolling.

After lunch, a clinical investigator provides a first-hand experience of mounting trials and the interests of the different groups involved in them: investigators, pharmaceutical companies, facilitators (such as the CTN) and participants.

The remainder of the afternoon is devoted to informed consent and participants have an opportunity to read a consent form and assess its strengths and weaknesses. The day ends with a panel discussion, with clinical investigators and nurses as well as a representative of the CTN's Community Advisory Committee.

Nearly 100 people called to register for the first workshop in Vancouver, April 10, resulting in a second workshop being offered in the city, May 29. Workshops in Montreal (May 8) and Quebec City (May 10) have also been well attended.

Dates for fall workshops have yet to be set, but, in collaboration with leading community organizations, the CTN hopes to offer sessions in Toronto, Winnipeg and Halifax in September and October. To find out more, please contact the Canadian HIV Trials Network, at 1-800-661-4664 or www.hivnet.ubc.ca/ctn.html. ■

CTAC in Winnipeg March 23-28



by Daryn Bond

Taking advantage of the convergence of HIV activists and researchers in Winnipeg for the 2002 Canadian Association of HIV/AIDS Research (CAHR) Symposium, CTAC hosted a skills building session and a press conference, in addition to participating in CAHR.

Following an introduction to CTAC, a small yet attentive crowd at the skills building session discussed treatment access issues in Manitoba. Sean Hosein from the Canadian AIDS Treatment Information Exchange (CATIE) presented Treatment Information 201. Paula Braitstein from the Canadian Trials Network (CTN) discussed HIV trials. Ron Rosenes spoke about Complementary and Alternative Medicines, and Louise Binder rounded off the day with Women's Issues.

Later that week, the local media attended a press conference on health care reform, HIV research and increased funding for the Canadian Strategy on HIV/AIDS. Hosted by CTAC, Louise Binder, Dr. Mark Wainberg, Martin Schecter (CTN) and Ken Rosenthal (CAHR) spoke to the

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PROVINCIAL UPDATES

BRITISH COLUMBIA *by Glen Hillson*

Since British Columbians elected a new provincial government last year, lotus land has undergone rapid change from its system of universal, publicly funded healthcare to dismantling that system through privatization and multi-tiered access.

De-listing of prescription drugs from the provincial formulary, hospital closures, and repealing health care collective agreements are some of the changes already taking place designed to pave the way for Americanization of healthcare in BC, placing the province in lockstep with Ontario and Alberta.

The local community movement has been prominent in the fight-back against the dismantling of BC's health care system. The BC Persons With AIDS Society (BCPWA) is the treatment advocacy arm of the community-based movement in BC and has strong ties with CTAC through that work.

BCPWA has been a member of the BC Health Coalition for several years. The Health Coalition, the BC Federation of Labour, seniors and anti-poverty groups have worked closely together to organize several public initiatives, including a twenty thousand strong rally at the BC legislature on February 23, 2002.

ONTARIO *by Enrico Mandarino*

The Ontario Treatment Network continues to collaborate with the Ontario AIDS Network (OAN) to work on treatment access issues for the province. On Friday, May 3rd a round table discussion was held at the OAN Caucus meeting, during which the Canadian Treatment Action Council provided an update on its activities. There will

be an opportunity at each of the OAN PHA Caucus meetings to discuss treatment access issues in Ontario. Another face-to-face meeting is being planned for November 2002, at which treatment activists will be offered a day of information sharing and skills building. We are currently working on the membership database and will be sending out detailed information about the various working committees set up in Ontario to deal with treatment access issues.

Dental Care Committee

Shari Margolese is chairing this committee and is organizing its first meeting to discuss access to dental care issues in Ontario. If you are interested in participating in this committee, please contact the CTAC office or e-mail shari@ctac.ca.

Ontario AIDS Strategy – Status Report

The information and recommendations from the two Delphi focus groups meetings held in October and November are being integrated into a draft strategy document. Once reviewed by the Strategy Working Group, it will be focus-tested in seven regions across Ontario. It will then go back to the Strategy Working Group, and then the Ontario Advisory Committee on HIV and AIDS (OACHA) for any final revisions. The AIDS Bureau is preparing an update on the strategy process for HIV stakeholders. OACHA hopes to have the Strategy, and recommendations to the Minister of Health by the end of June.

ALBERTA

by Bob Mills

The University of Alberta Clinic in Edmonton can now

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PROVINCIAL UPDATES

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complete its own Genotypic Resistance Testing. In the past, such tests were sent to the BC Centre for Excellence in HIV/AIDS in Vancouver. Tenofovir is available for expanded access trials in both Edmonton and Calgary, which are currently enrolling. The IL-2 international access trial has two candidates enrolled in Edmonton.

Update on Health Care Reform

At the February 26th Alberta Partnership for Health meeting in Calgary, CTAC and ACCH Representative, Bob Mills, had an opportunity to report on and lead a discussion on how the Mazankowski Report views individuals living with disabilities. The conclusion from this discussion is that there is a strong focus on health and staying well, but that people currently living with a disability or chronic illness, and/or seniors, are seen as a "burden to the health care system".

The Alberta Partnership for Health's mission is to provide health care providers and representatives of consumer-based health organizations opportunities to develop and implement joint initiatives to improve quality of life by focusing on quality of care. It is interested in report backs from the various consumer and HIV/AIDS groups presenting abstracts or submitting news releases on health care reform. Their web site address is: <http://www.albertadoctors.org/advocacy/partnership/index.html>.

Abstracts were submitted to the Romanow Commission in both major centres on behalf of the Alberta CTAC Representative, ACCH, AIDS Calgary and HIV Edmonton as well as by individuals living with HIV/AIDS. All abstracts strongly supported maintaining the five principles of the Canada Health Act. They stated that the quality of access to care and support must be addressed without the introduction of a two-tier system of delivery

and the federal government must be held accountable for increasing and sustaining funding to the provinces so they can adequately provide public health care. Bob Mills presented on May 14th at the Public Consultations in Edmonton on behalf of people living with HIV/AIDS.

The Alberta Medical Association (AMA) web site contains AMA observations on the government's plan to implement the Mazankowski report, as well as background papers. See <http://www.albertadoctors.org/advocacy/sustainability/index.html> for more information. ■

CTAC in Winnipeg

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media. The directors of CAAN, CAS and the HIV/AIDS Legal Network were all in attendance to answer questions and show support. Afterwards, an energetic, vocal group held a public demonstration to draw attention to HIV/AIDS and health care reform.

Reaching Out at Home and Abroad was the theme for this year's CAHR Symposium. Social scientists and epidemiologists focused on global issues, vulnerable populations, safe injection facilities for intravenous drug users and hotly debated the perceived separation of prevention from treatment. With the exception of a few drugs in development, new drug combinations and a better understanding of viral mechanics, no earth-shattering announcements came from the scientific community. It was speculated that researchers were saving their big announcements for the International AIDS Conference to be held this July in Barcelona. Thanks to all who participated and supported these events, making Winnipeg, for one week, the center of HIV advocacy and research. ■

CALENDAR OF EVENTS

SUMMER 2002

● **July 7th-12th**

XIV International AIDS Conference

Barcelona, Spain

Contact: aids2002@aids2002.com or
(+34) 93 254 0555

● **September 27th-September 30th, 2002**

**42nd Interscience Conference on
Antimicrobial Agents and Chemotherapy**

San Diego, California

Contact: (202) 737-3600 or
ICAAC@asmusa.org

● **October 6th-7th, 2002**

**Canadian Treatment Action Council
Annual General Meeting and
Skills Building**

St. John's, Newfoundland

Contact: ctac@ctac.ca or (416) 410-6538
Join CTAC for a day of skills building in St.
John's! All are welcome to attend. Please
see www.ctac.ca for details and to register
for the day.

● **October 22nd-25th, 2002**

**Alberta Community Council on Health
(ACCH) Membership Meeting**

Jasper, Alberta

Contact: Jennifer Vanderschaeghe at
(403) 314-0892 or acch@shaw.ca

CHAIR'S REPORT

SUMMER 2002

by Louise Binder

When did politicians start to see their role as accountants – bean counters, and that all that governing means is ensuring that the budget is balanced?

When did they stop seeing their role as making decisions based on the values that Canadians have told them, in poll after poll, they hold sacred?

Those values involve much more than a balanced budget at the expense of people's lives and well being. Canadians still believe in the common, as well as the individual, good. Sadly, the influence of our neighbours to the south and other international business interests are working at eroding this basic Canadian value, with our leaders' complicity in the conspiracy.

This has been evident for some time, NAFTA being the first profound public manifestation of the change in public policy. This was followed by the great deficit scare. Although Canada had managed to stay afloat as a nation without a balanced budget, the deficit suddenly became a major obstacle.

The most recent great "crisis" is the funding of our public health care system. Yet, are we really in crisis? And if we do need to do something to preserve the system as it is, why is that the fault of Canadian citizens? Why must we fix a problem that politicians and their business friends created by cutting transfer payments and making international trade deals, among other policies?

Don't buy into the great health care crisis any more than the great deficit catastrophe. These are acts of man, not nature, and they can be corrected without any shift in the basic values that Canadians hold dear, including universal public health care.

The federal government did not run on a platform of dismantling health care. It has no mandate from the people of this country to do so without a referendum.

CTAC recognizes this as a fundamental issue of access to treatments for people with HIV/AIDS. We will be heard loud and clear in this debate. We hope you will join us. Our lives depend on it.

Please visit www.ctac.ca to follow CTAC's efforts and to find out how you can get involved. ■

COUNCIL MEMBERS

BOARD OF DIRECTORS

- CHAIR **Louise Binder** Toronto People With AIDS Foundation (TPWAF)
 - VICE CHAIR **Glen Hillson** British Columbia
 - TREASURER **Tony Di Pede**
 - BOARD SECRETARY **Darren Greer** Canadian Aboriginal AIDS Network (CAAN)
 - ACTING BOARD SECRETARY **Daryn Bond** Manitoba
- Philip Lundrigan** Newfoundland & Labrador
- Enrico Mandarino** Ontario
- Shari Margolese** National Women's Representative
- Ron Rosenes** AIDS ACTION NOW! (AAN!)

-
- George Clark-Dunning** Prince Edward Island • **John Arenburg** Nova Scotia • **Emerald Gibson** New Brunswick • **Line Carreau** Québec • **Bob Mills** Alberta • **Lelah Ngeruka** Territories • **Tom McAulay** British Columbia Persons with AIDS Society (BCPWA) • **Donald Raymond** Coalition des organismes communautaires québécois de lutte contre le sida (COCQ-Sida) • **Françoise Grothé** Comité des personnes atteintes du VIH du Québec (CPAVIH) • **James Kreppner** Canadian Hemophilia Society (CHS) • **Gerard Yetman** Canadian AIDS Society (CAS) • **Richard Elliott** Canadian HIV/AIDS Legal Network

2001/2002 FUNDERS

- Health Canada
- Abbott Laboratories • Boehringer Ingelheim • Bristol-Myers Squibb • Gilead Sciences • GlaxoSmithKline in partnership with Shire BioChem • Hoffmann-La Roche • Merck Frosst • Ontario HIV Treatment Network (OHTN)

CTAC POSITION PAPERS AND SKILLS BUILDING VIDEOS

Papers

- 2001 – “Improving our Health: The Need to Enhance the Post-Approval Surveillance System for HIV/AIDS Drugs in Canada”, author: David Garmaise.
- 2001 – “Making Treatments Accessible: A Policy Paper on Determining Appropriate Pricing for Brand-name Pharmaceutical Treatments for HIV/AIDS in Canada”, author: Glen Brown.
- 2000 – “Position Paper on Direct To Consumer Advertising (DTCA) of Prescription Medications”, author: Phillip Lundrigan.
- 1999 – “Timeliness and Transparency: Assessing the Review Process for HIV Drugs”, author: David Garmaise.

Video Tapes

- 2001 – “New Drug Reviews and Research: What's the Rush?” – \$9.00
- 2001 – “Making Room for CAM: Advocacy Issues regarding Complementary and Alternative Medicine (CAM)” and “How to Lobby Politicians and Bureaucrats Effectively” – \$11.00

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- Group, organization and/or project with a substantive HIV/AIDS mandate

Associate Membership

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- Group, organization and/or project whose substantive mandate coincides with the objectives of the Corporation

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