
Medical Reform

Newsletter of the Medical Reform Group

Issue 146

Volume 28, Number 3

Winter, 2009

MRG STEERING COMMITTEE ENDORSES JEFF TURNBULL FOR CMA PRESIDENT

Traditionally the Medical Reform Group has limited its interest in the internal politics of the Canadian Medical Association to a review of resolutions or issues likely to come to the floor at Annual Council Meetings each summer.

This year, however, the Steering Committee has endorsed one of the three presidential candidates put forward for election by Ontario members, and eventually, ratification by the full Council in August for a term beginning in 2010. This newsletter features 3 short items on Dr. Jeff Turnbull and this very important election and we encourage you to review this information before casting your ballot.

1. Who is Jeff Turnbull?

Jeff Turnbull is an extraordinary physician. He has served as President of the College of the Physicians and Surgeons of Ontario and President of the Medical Council of Canada. He was Chair of the CMA's Future of Medicine Project and a leader of the Educating Future Physicians for Ontario project.

Most impressive about Jeff is his broad perspective on health and health care, his work in making medical education more responsive to the

needs of the community, and his dedication to caring for marginalized populations.

Jeff is currently Chief of Staff at The Ottawa Hospital and Medical Director of the Inner City Health Project, which has won national and international recognition for its cost-effective care of homeless men. He has also been helping develop health projects in Bangladesh, Kenya and Nigeria. Jeff has received the Order of Canada for his humanitarian work.

Jeff believes in practicing medicine based on evidence, and in

implementing health care policy based on evidence. Throughout his career, he has fostered productive working relationships with multiple partners, including the CMA, the OMA, and the federal and provincial governments.

The Steering Committee believes a vote for Jeff is a vote for effective leadership and meaningful change within our publicly-funded system. If you want to read more about Jeff a good place to start is a recent Ottawa Citizen profile. You can find it on his website at www.jeffturnbull.ca under Jeff in the media.

You may not have voted in previous CMA or OMA elections, but your vote can make a difference to the way our health care system works. The President of the CMA has the power to influence health policy decisions, and the way the public perceives our role. We are entering a time of extraordinary economic difficulty. We are likely to see challenges to a system that is already fragmented and under-resourced; and sometimes poorly governed.

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Medical Reform

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Articles and letters on health-related issues are welcome--please forward electronically to medicalreform@sympatico.ca.

Contact us at:

MEDICAL REFORM

Box 40074, RPO Marlee

Toronto, Ontario M6B 4K4.

Telephone: (416) 787-5246

Fax: (416) 352-1454

E-mail: medicalreform@sympatico.ca

Opinions expressed in **MEDICAL REFORM** are those of the writers and not necessarily of the Medical Reform Group.

Editorial committee this issue: Rosana Pellizzari, Gordon Guyatt, Janet Maher

The Medical Reform Group is an organization of physicians, medical students and others concerned with the health care system. The Medical Reform Group was founded in 1979 on the basis of the following principles:

1. **Health Care is a Right.** The universal access of every person to high quality, appropriate health care must be guaranteed. The health care system must be administered in a manner which precludes any monetary or other deterrent to equal care.

2. **Health is Political and Social in Nature.** Health care workers, including physicians, should seek out and recognize the social, economic, occupational, and environmental causes of disease, and be directly involved in their eradication.

3. **The Institutions of the Health System Must Be Changed.** The health care system should be structured in a manner in which the equally valuable contribution of all health care workers is recognized. Both the public and health care workers should have a direct say in resource allocation and in determining the setting in which health care is provided.

EDITORIAL NOTES

Janet Maher

The range of news reported in this issue is a testament to much of the routine work we do in coalition.

The province of Ontario released its long-awaited Poverty Reduction Strategy in December and certainly took into account the persistent pressure of the advocates of 25 in 5, the community coalition which has focused on getting 'bold action' on poverty reduction. While the government's approach still leaves much to be desired, particularly with regard to access for the most vulnerable Ontarians, it will continue to be a focus of mobilizing over the next period.

The return of Conservatives as a minority to the House of Commons has entailed continuing vigilance, particularly with more ominous news over the fall of a period of recession. We look forward to the return of parliament and the 2009 budget in the coming weeks for signs that the federal government is beginning to take seriously the need for a more collaborative approach.

This issue features highlights from two recent initiatives undertaken by the Ontario Health Coalition. *Eroding Public Medicare* has caught the attention of observers across the country for its thoroughness in documenting gaps in enforcement of the Canada Health Act. *Home Care We Need* gives a snapshot of the pathetic state of home care in the province with some 20 recommendations for action by the various stakeholders. MRG members contributed to both initiatives, and the Steering Committee is looking forward to a discussion February 5th with OHC Director, Natalie Mehra on hospital and other service cuts.

Featured on the back page of this issue is news about preparations

by Students for Medicare for a conference in which they expect to educate themselves and plan for advocacy on maintaining and enhancing publicly-funded health care in our country.

Students for Medicare represents medical and health sciences students and residents at post-secondary institutions across the province who recognize the need for more focused advocacy. To assist them in putting on the conference, the Steering Committee has recommended an appeal as a tribute to long-time Steering Committee member Mimi Divinsky who passed away in February, 2007.

With regard to the bylaw review begun a year ago, members received ballots with their last newsletter on a package of constitutional amendments aimed at updating and streamlining decision-making processes and facilitating a more modern approach to debate and decision-making. Of 68 ballots returned, only one opposed the amendments proposed, so their have been declared adopted. In the coming weeks, the Steering Committee will be reviewing and recommending changes to our process, which we hope will facilitate more participation at a distance in our work. Stay tuned! ♦

MRG STEERING COMMITTEE ENDORSES JEFF TURNBULL FOR CMA PRESIDENT (continued)

2. How to Vote

If you are an eligible voter, you should have received election information and a mail-in ballot around January 10th, 2009. Voting starts January 15th, and ends February 26th, 2009, and you can vote either by mail or via the internet.

You will need your OMA membership number, website password, and the voting information on the ballot. If you don't receive a ballot, or have lost your ID/password, e-mail sharmann_grad@oma.org with your name and address.

3. Jeff Turnbull's platform in his own words

I want to take this opportunity to tell you what my top 3 priorities will be if elected president:

Innovating to strengthen Medicare.

The strengths of our publicly funded health care system are many—but Medicare needs to be better. Wait times are too long, care is often frag-

mented, there are too few physicians, many patients do not get the medications they need, and physicians are being asked to do things that other health providers should be doing instead.

Across our country, small programs are being used to address some of these issues—but they are not being implemented across the system to benefit all our patients.

✓ As CMA president, I will seek out and highlight best practices for improving healthcare. I will insist that both CMA and governments use evidence and best practices to drive policymaking.

Physician wellbeing. From medical students to physicians nearing retirement, doctors at all stages of their careers are facing unprecedented stress. Medical student tuition is higher than it has ever been before, and the economic crisis has decimated the savings of many physicians nearing retirement.

Burnout is high and physicians feel their futures are uncertain.

✓ As CMA president, I will advocate for pensions, changes in tax law, and debt relief. I will also continue the good work CMA has been doing on other aspects of physician wellbeing since financial wellbeing is only one small piece of the puzzle.

Engaging physicians in their professional associations. The OMA, CMA, CPSO, RCPSC and CFPC are our organizations, and their policies should be driven by our needs and those of our patients.

✓ As CMA president, I will ensure that all physicians who want be involved are actively engaged, and I will make it a priority to ensure that physician organizations are seen as the most credible source of health policy recommendations. ♦

Jeff Turnbull, CM MD MEd FRCPC

DOCTORS' GROUP TO GOVERNMENT: NO HEALTH CARE CUTS

A Canadian physicians' group has called on governments to refrain from cutting public services and programs, in particular health care, in response to the economic crisis.

"The current problems in health care, including excessive waiting lists and difficulty finding a family doctor, are a result of health care cuts of the 1990's, and governments' unwillingness to remedy those cuts," said Medical Reform Group spokesperson Gordon Guyatt. "Further cuts to the system are unnecessary, and would be disastrous."

Canada's recession of the early 1990's created large budget deficits. Paul Martin responded by huge transfer payment cuts to provinces in the mid-1990s, cuts that compromised high quality health care for Canadians.

The initial cuts to social programs, in particular health care, were more draconian than necessary. The economy rebounded in the mid 1990s, but rather than restoring adequate funding, governments awash with extra dollars implemented huge tax cuts. Subsequently, misguided priorities and unwillingness to commit to needed reforms have left the system struggling.

"Economies go through cycles," said another MRG spokesperson, Dr. Ahmed Bayoumi. "Panic is the wrong response to any downturn, and this downturn in particular. If governments refrain from additional tax cuts, the economic revival we will see within several years will reverse any temporary deficits. Rather than further compromising quality health care, we need to continue to rebuild the damaged Canadian health care system." ♦

*Released by the Medical Reform Group
November 3, 2008*

ERODING PUBLIC MEDICARE

Natalie Mehra

We present excerpts of the executive summary of a landmark report released October 6th, 2008

In researching this report, we set out to find all the for-profit diagnostic, surgical and “boutique” physician clinics across Canada. Our goal was to measure the impact of for-profit privatization. How is it affecting costs and access in the public system? How many clinics are violating the Canada Health Act? Where are they taking their staff from and how is that affecting access to public non-profit services?

Our main findings, in brief:

1. Across Canada in total we found 42 for-profit MRI/CT clinics, 72 for-profit surgical hospitals (clinics) and 16 boutique physician clinics. The surgical clinic numbers exclude those that sell only medically unnecessary cosmetic surgery and other such procedures and abortion clinics that arose as a special case.
2. Among these clinics we found evidence to suspect 89 possible violations of the Canada Health Act in five provinces.
3. An increasingly aggressive group of private company owners who are pushing provincial governments to give them publicly-funded contracts to increase their revenues (and profits).
4. A significant number of private clinics are now openly selling two-tier health care for medically-necessary services. In addition, a notable percentage are billing the public plan and charging patients in addition, by co-mingling medically necessary and unnecessary services in an attempt to sidestep the Canada Health Act.
5. The number and scope of private clinics has been growing since the deep cuts to healthcare transfers and hospitals in the mid 1990s. Their expansion has increased in the last five years.
6. This is a new phenomenon. The first for-profit MRI clinics were opened only ten years ago, and the majority have opened in the last five years. Almost all the for-profit surgical clinics and boutique physician clinics have opened in the last five years.
7. To date, every region of the country has been the target of for-profit clinics’ expansion, except PEI, the Northwest Territories, Yukon and Nunavut.
8. A change in for-profit clinic ownership from small locally-owned companies to chains and U.S.-led multinationals is beginning to take place that holds grave implications. Some of the MRI/CT clinics are chains, some multinational. The first chains and U.S. multinational corporate takeovers of surgical clinics have emerged in the last two years. In the last several years also, at least one country-wide chain is emerging in boutique physician clinics.
9. We found evidence of wait times that are highest in areas with the most privatization as resources – financial and human – are taken out of the public health system.
10. We found a demonstrable reduction in capacity of public non-profit hospitals as a direct result of staff poaching by nearby private clinics. In at least three provinces, hospitals have been forced to reduce or close down public services due to shortages worsened by staff poaching from nearby for-profit clinics.
11. We found that out-of-pocket costs charged by private clinics are beyond the financial reach of most of the population in those provinces.

The majority of for-profit clinics are maximizing their profits by charging public plans and charging patients out-of-pocket or through third-party insurance as well. The evidence shows that for-profit delivery erodes the public health system by taking financial and human resources out of the public system and by promoting two-tier health care.

In many cases, the drive of clinics to maximize revenues by billing all available sources – governments, patients and third-party insurers – is jeopardizing the equality and fairness of the public system which is supposed to assure equal access to medically-necessary hospital and physician services regardless of wealth.

There is little evidence to support the contention that for-profit ownership bears any relation to reducing wait times. In fact, in demonstrable cases, for-profit clinics have forced reductions in local public and non-profit hospitals’ services and have charged higher fees. Several provinces, including Ontario, Alberta and Manitoba, have in recent years reversed for-profit ownership and building capacity in the public healthsystem, thereby improving access on an equitable basis.

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ACKNOWLEDGING THE NEW MINISTER OF HEALTH AND NEW LIBERAL LEADER

The Steering Committee wrote letters of congratulation to the new federal Health Minister, the Hon. Leona Aglukkaq, and Michael Ignatieff, the new Liberal Opposition Leader, on December 15th, 2008

The Honourable Leona Aglukkaq, P.C., M.P.
Health Canada
Brooke Claxton Building, Tunney's Pasture, Postal Locator: 0906C
Ottawa, Ontario K1A 0K9

Dear Ms. Aglukkaq:

I am writing on behalf of the Medical Reform Group to congratulate you on your recent appointment at the Minister of Health and offer our advice and counsel on maintaining a strong role for public health care in Canada.

The Medical Reform Group was founded in 1979 as a voluntary association of physicians and medical students with an interest in promoting and enhancing public health care in our country. Our members are family physicians and specialists in a range of disciplines include many leading experts in the field of evidence based medicine, who have experience on a wide range of medical and health policy issues including innovative delivery models and strategies for improving system access and equity.

We would value an opportunity to meet with you and your staff at your earliest opportunity. ♦

Michael Ignatieff, MP
Leader of the Official Opposition
House of Commons
Ottawa, Ontario
K1A 0A6

Dear Mr. Ignatieff,

I am writing on behalf of the Medical Reform Group to congratulate you on your recent assumption of the role of Leader of the Official Opposition, and offer our advice and counsel on maintaining a strong role for public health care in Canada.

The Medical Reform Group was founded in 1979 as a voluntary association of physicians and medical students with an interest in promoting and enhancing public health care in our country. Our members are family physicians and specialists in a range of disciplines include many leading experts in the field of evidence based medicine, who have experience on a wide range of medical and health policy issues including innovative delivery models and strategies for improving system access and equity.

We would value an opportunity to meet with you and your staff at your earliest opportunity. ♦

ERODING PUBLIC MEDICARE (continued)

The evidence shows that where the federal and provincial governments have acted to halt violations of the Canada Health Act, they have succeeded.

But no province has adequate regulatory and enforcement regimes to stop the extra charges and two-tiering that is threatening equal access to care. And the federal government

is not enforcing the Canada Health Act to protect patients from increasingly aggressive attempts to dismantle equal access to health care for all Canadians. ♦

LOBBY LETTER ON FEDERAL BUDGET

The Steering Committee wrote the Finance Minister on January 12th, 2009, with copies to the leaders of each of the opposition parties, as part of a 25 in 5 coalition effort to underline the importance of investments to meet the needs of the most vulnerable.

I am writing to urge you to make social investments and poverty reduction top priorities in the upcoming January 27 federal budget.

Evidence is mounting that investments in infrastructure such as affordable housing and early learning and child care, along with strengthening the incomes of vulnerable families and adults, will reduce poverty while at the same time creating jobs and stimulating demand in local economies across Canada.

On the other hand, general tax cuts have been shown to be ineffective and a weak substitute for social investments when it comes to economic stimulus. As you weigh your options for a stimulus package that can put our economy back on track,

I would like to share with you 3 reasons why social investments make for smart economic policy and 3 reasons why general tax cuts are **not** the answer.

Three Reasons why Canada's economy needs social investments:

1. **Social transfers do double duty of protecting Canadians in tough economic times and stimulating local economies**—EI reforms, the Canada Child Tax Benefit and the Work Income Tax Benefit cushion the blow for the most vulnerable while putting money into the pockets of those who are most likely to spend it on food, rent and other necessities stimulating their local economies.

2. Investments in social infrastructure create jobs and contribute to strong and supportive communities

—investments in building and repairing affordable housing, early learning, child care and education services not only create jobs and economic spin-offs, but also bring the most benefit to those who live on the margins.

3. The cost of poverty is too great:

we can make smart investments now to ensure everyone is at their best, or we can pay much more later in remedial expenses. Poverty costs Canada \$38 billion a year due to high unemployment, increased costs of health and social services, policing and criminal justice systems.

Three reasons why general tax cuts don't make economic sense:

1. **Most of the money from tax cuts is not spent in local economies...** tax cuts for middle and high income earners ends up in savings or is used to pay down personal debt. TD Bank economist Craig Alexander points out that of the \$100-billion in stimulus cheques issued by the Bush administration last spring, 80 cents from every dollar went into savings accounts, 10 cents into imports, 10 cents into domestic spending

2. **Tax cuts erode the government's revenue base** taking away our ability to invest in anti-poverty and other initiatives resulting in further cuts to social programs in order to produce balanced budgets.

3. Income supports benefit low-income Canadians and local economies...

child benefits, work income supplements and employment insurance are efficient vehicles for transferring money into local economies and protecting the living standards of those who have the least

I look forward to a budget on January 27 that can both provide an effective stimulus package as well as address the goal of poverty reduction

Sincerely,
The Steering Committee,
Medical Reform Group

cc. Michael Ignatieff, Leader, Liberal Party

Jack Layton, Leader, NDP

Gilles Duceppe, Leader, Bloc Quebecois ♦

RECESSION RELIEF FUND

Since the federal election and acknowledging the increasing evidence that the economic downturn was likely to be with us for a year or more, many advocates increased their pressure on the minority government to keep in mind the need to provide relief to our communities and their vulnerable citizens is an urgent priority for the budget and the work to be done in the 40th Parliament.

Background:

The Looming Crisis

With a recession under way, the need for services provided by the front line agencies serving Canada's most vulnerable will increase.

It is anticipated that all levels of government, faced with deficits and declining tax bases will cut spending. Social spending grants to agencies are not seen as core spending and are often the first things to be cut.

In addition, Foundations and individuals, facing 30 per cent plus hits to their equity portfolios are likely to cut back on charitable giving. Corporations facing layoffs, decreasing profitability and in many cases fighting for survival will likely cut back on charitable giving and philanthropic sponsorships.

At a time of increased demand and decreased revenues, many agencies will be very hard pressed to maintain service levels. Some agencies may be forced to lay off staff, cut programs and even close their doors creating greater crowding, demand and pressure on those remaining. At the same time, more and more people will require help.

The result will be an increase in the number of homeless men, women, children and families. There

will be overcrowding in shelters, deteriorating health conditions and increased mortality. Increasing levels of extreme poverty will lead to higher costs to the healthcare system, criminal justice system and remedial social services.

The Recession Relief Fund Declaration

We call on the Federal Government to immediately create a Recession Relief Fund which will include:

- ◆ preventing spending Cuts to public and private not for profit agencies serving vulnerable people including children, youth, families, immigrants, those who are homeless, un/under-employed, senior citizens, people who are disabled and those suffering from mental illness. (some funding programs are set to expire March 31, 2009)

- ◆ increase funding to all HRSDC (Human Resources and Social Development Canada) and settlement programs, including doubling the existing level of funding being provided through the HPI (Homeless Partnerships Initiatives) program to supplement funding that is projected to be lost from private sector sources and increase funding levels as required.

In addition, we call upon the Federal Government to invest a portion of proposed infrastructure spending on social infrastructure by implementing a fully funded National Housing Program. ◆

For more information see www.socialplanningtoronto.org/recession_relief_fund.html

SICK AND TIRED OF BEING SICK AND TIRED

The Community Social Planning Council of Toronto has designated its next research day, Monday, February 9th, 2009 at the Central YMCA Auditorium in Toronto, as an occasion to review the issues around poverty and health.

The February 9th forum, Sick and Tired of Being Sick and Tired, highlights new Social Planning Council research in the area of income, labour markets and health.

The morning session will include a presentation on new research with the official release of a new report, *Sick and Tired: The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario*, and highlighting the recent report, *Poverty is Making Us Sick: A Comprehensive Survey of Income and Health in Canada*.

The morning session will include a keynote address by Dr. David McKeown, Toronto's Medical Officer of Health and afternoon sessions focus on active campaigns on related public policy issues. Member Gary Bloch will participate in the panel on poverty and health.

Entrance to the Research Day is free, but requires pre-registration. Go to the Toronto Community Social Planning Council website at www.socialplanningtoronto.org ◆

ONTARIO POVERTY REDUCTION STRATEGY

Janet Maher

On December 4th, 2008, the Ontario Government released its long-expected poverty reduction strategy and there is some evidence that the concerted 25 in 5 campaign had some effect.

However, although the newly announced poverty strategy met the letter of the 5 tests enunciated by the campaign, it is clear there is a long way to go, and vigilance will be needed to maintain accountability, particularly in the light of current forecasts of serious recession through 2009-10.

Highlights of the Poverty Reduction Strategy

Most prominent in the government plan is the target of reducing the number of children living in poverty by 25 per cent over 5 years—in their words—raising 90,000 children out of poverty.

As expected, Premier McGuinty claims credit for beginning the strategy with his 2008 budget with investments in dental services, school nutrition and affordable housing maintenance and repairs, as well as increases in social assistance rates and the provincial child benefit.

Annual increases over the next 5 years to the Ontario Child Benefit will increase the income support to a \$1,310 annually by 2013. complementary initiatives provide support for full-day kindergarten for 4- and 5-year-olds, parenting centres and other social supports, particularly in low-income neighbourhoods and focused on youth at risk.

At least as important as direct investments to low-income families are commitments accountability and an acknowledgement of the need for

legislative review to remove some of the perverse disincentives which have complicated the lives of vulnerable Ontarians.

Adoption of the Low Income Measure (LIM—a measure which represents 50 per cent of the median income) is a step in the right direction and will provide a bench mark against which to measure the government's performance. Many advocates also lauded the announcement of a review of social assistance to realign programs to meet the needs of recipients.

How the Poverty Reduction Strategy measures up

The community coalition, 25 in 5, of which the Medical Reform Group is a member, has been vigilant over the past 18 months in building consensus within its membership and pressing the government to move boldly—a lobby effort ramped up over the fall of 2008, as news began to penetrate about the impacts of the recession.

Following a community meeting in October, 2008, they outlined 5 tests for the anticipated poverty reduction strategy.

1. Explicit target to reduce poverty in Ontario by 25 per cent over the next 5 years.

Building on commitments already made in the 2008 provincial budget, the government focuses its attention on reducing child poverty through expansion of the provincial child benefit and expansion of a range of community services focused on children.

Most Coalition members have focused their response on recog-

nizing the fact that poor children are at higher risk because they come from families in poverty. Some advocates, among them the Health Providers Against Poverty, are concerned that some of the most vulnerable, single older men and women, are all but invisible in the strategy.

Other more general concerns focus on the dependence, at least in government communications on the poverty reduction strategy, on anticipated federal supports to give the monetary targets much substance.

2. Clear way to measure progress with agreed-upon performance indicators

The Low Income Measure is a start and provides international comparability as well as a clear yardstick to track outcomes. The government has recognized the need for additional indicators in the areas of health, education, housing and relative deprivation.

The coalition will continue to lobby for specific indicators around income security and impacts on population-specific groups who have at least recently, been over-represented at the lower end of the income scale—newcomers, racialized groups, aboriginal people and people with disabilities.

3. Policy specifics on social assistance, housing and labour market security

The coalition called for commitments in 3 priority areas, including sustaining employment, livable incomes and community supports. The plan released by the

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ONTARIO POVERTY REDUCTION STRATEGY (continued)

government makes modest commitments in 6 areas as follows:

◆ Social assistance reform: although short on details, the strategy focuses on reducing barriers and increasing opportunity, acknowledging the need for better alignment of benefits (access to drug, dental and other benefits) and conditions (earnings limits before basic benefit is reduced or eliminated) to facilitate the transition to employment of those social assistance recipients whose need for benefits is temporary. There is, unfortunately, no mention of the most vulnerable, single older men and women unlikely to be in a position to [re]enter the work force

◆ Improvements to affordable housing: beyond a commitment to include social housing infrastructure and maintenance in the more general infrastructure and economic stimulus investments, and some improvements to the provincial rent bank (which provides assistance to residents of private sector housing at risk of homelessness), the main action in housing will be dependent on an Affordable Housing Review only scheduled to start later in 2009.

◆ Labour market initiatives: moves to increase the minimum wage to \$10.25 an hour by the end of 2010, to regulate temporary agencies and to improve enforcement of existing employment standards are steps in the right direction to addressing the issues of the working poor.

◆ Improvements in early learning and child care: advocates were pleased to hear the govern-

ment's recognition of the importance of early learning in child development, and supports for provincial parenting centres will be welcomed by families who have access to them. However, without significant investments in child care, many young mothers of moderate means will find the transition from benefits to employment difficult if not impossible.

◆ Community initiatives: the announcement of a \$5 million investment in a Community Opportunities Fund to encourage local partnerships in neighbourhood revitalization has the potential to facilitate community involvement.

◆ Federal partnership: As noted, the McGuinty government has called on the federal government for significant assistance in implementing its ambitious plan, and for the first time in a generation, has actually committed to spend whether or not federal contributions are forthcoming.

However, it is clear that the bigger ticket items (infrastructure and income support) are unlikely to be taken up seriously in the absence of additional funds. In addition to the direct cash expected by the province, the 25 in 5 coalition has called on the federal government to consider increasing its supports through increases in the working income tax benefit and national child benefit and review of employment insurance to provide greater access of the 60 per cent of those who pay into the fund but are unable to collect.

4. Legislated plan for accountability: As urged by 25 in 5, the government has committed to enacting the poverty reduction plan into law, with annual public reporting and consultation as the plan unfolds with low income leaders, advocates and experts.

5. Evidence of good intent and a down payment in the 2009 budget.

The new Ontario Poverty Reduction Strategy provides a 'floor' of investments on which they are committing to build, but the December announcement was remarkably free of any announcements over and above those already made public in the 2008 budget.

Almost daily news of the impacts of the recession, where increasing numbers of younger Ontarians are finding that formerly secure middle class life style is at risk because of corporate downsizing and many approaching pension age have suddenly been left in the lurch as their private pension income has been reduced by 20 to 50 percent in the market meltdown. Some of these horror stories will add to the toll of poverty which has for the most part not directly affected middle class Ontarians.

For more information on the provincial government plan, see www.growingstronger.ca and on the strategy and lobby plans of 25 in 5, see www.25in5.ca ◆

EQUITY FOR NEWCOMERS TO ONTARIO

For several years, Ontario has risked a human rights challenge with its persistence in requiring newcomers to wait 3 months for OHIP eligibility, resulting in needless and costly delays in care. On January 12th, 2009, the Medical Reform signed on to the following lobby effort.

We are a group of Ontario health care providers from numerous different disciplines. It has come to our attention that there are legislative changes proposed by the provincial government that will impose a 90 day residency requirement on refugees that arrive in Ontario. We are deeply concerned about this current proposal and are writing this letter to document our concerns.

We strongly believe that refugees comprise some of the most vulnerable members of our society. Many of us have had the privilege of working with refugee patients soon upon arrival in Ontario. The majority of these patients have lived through very severe physical and mental trauma. Many have lost family members or have suffered from torture. Nevertheless they usually arrive in Ontario with immense optimism and a tremendous commitment to rebuild their lives. Despite the numerous cultural, economic and social challenges, many refugees flourish upon arrival in Ontario.

We are tremendously disappointed at the attempt to impose a 90 day wait to obtain provincial health insurance upon this group. We feel strongly that refugees should be provided with health assessments soon upon arrival in Ontario. Early assessment allows for the identification of subclinical illnesses and for the implementation of preventative strategies. We feel this will facilitate the integration of newly arrived refugees and will also serve to identify illness at a point before treatments become more expensive. Early assessment also serves for public health concerns to be addressed. For ex-

ample, identification of people that may be carrying tuberculosis may allow for treatment before active tuberculosis becomes an issue. Detection of hepatitis B carriers may allow for vaccination of contacts before they are infected. We believe that any impediment to accessing health care, particularly in the early periods of migration, will delay the diagnosis of illness. This does not serve the interests of refugees nor the rest of Ontario society.

We recognize that there are other forms of health insurance coverage. The costs of private insurance make it unrealistic for refugees. The Interim Federal Health (IFH) program is available to refugees soon upon arrival in Canada. We want to draw your attention to the perceived limitations of this program.

Many physicians and other institutions do not accept IFH and it becomes an unreasonable expectation for newly arrived refugees to be able to negotiate the health care system when their coverage is denied by a health care provider. We are concerned that these refugees will not have their concerns addressed until their OHIP coverage takes effect. IFH is a program that provides emergency services.

Many health care workers will not access it for services such as immunizations, TB testing or even what they perceive as minor illnesses. Unfortunately some of these minor illnesses can lead to more severe illnesses if not addressed early. Delaying preventative interventions can also result in significant illnesses. We do not feel that IFH can provide the insurance coverage to provide adequate health care to this group.

We are asking you to carefully consider this proposed change. We feel strongly that refugees should be entitled to provincial health insurance upon arrival in Ontario. We believe that this government is sensitive to the plight of this vulnerable population and we are confident that you will reconsider your decision. ♦

Copies to Health, Education and Social Policy Committee members

P3 DISASTER DEMANDS CHANGE, DOCTORS SAY

Responding to the report of the Provincial Auditor General about the financing and building of the Brampton Civic hospital, a Canadian physicians' group has called for the Ontario government to reverse its plans to use the public-private mechanism for construction of new hospitals.

"The government has ignored repeated warning calls about private-public partnerships," said Medical Reform Group spokesperson Gordon Guyatt. "Will they pay attention to an auditor's report? We sure hope so."

The new Brampton Civic hospital could have cost the government at least \$50 million less if it was not built by the private sector, Ontario's Auditor General Jim McCarter has found. On top of the extra construction costs, had the province financed the building at a rate in line with available borrowing rates it would have saved \$200 million over the term of the project's P3 arrangement, the auditor's report noted.

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HOME CARE: CHANGE WE NEED

Carol Kushner and Pat Baranek released this Report on the Ontario Health Coalition's Home Care Hearings, on November 17, 2008. Excerpted here are highlights and recommendations from the executive summary.

In January 2008, the Ontario government imposed its second province-wide moratorium on competitive bidding in home care.

This decision encouraged the Ontario Health Coalition, with support from the Service Employees International Union to appoint a three-person panel (Carol Kushner, Patricia Baranek and Marion Dewar) to conduct public hearings on home care in five cities in Ontario: Toronto, Sarnia, Peterborough, Ottawa and Thunder Bay.

In total, the panel heard 78 presentations and received 69 written submissions from individuals and/or organizations from across the sector including clients and caregivers, concerned citizen and public interest groups, front-line home care workers (personal support workers, nurses, therapists, and social workers), unions, and non-profit home care agencies.

The panel regrets not hearing from the Ontario Association of Community Care Access Centres or any individual CCAC but understands that they are not permitted to engage in what might be perceived as advocacy. Also, although the panel regrets not hearing from any individual for-profit provider organization, it did receive a submission from the association representing their interests. The sponsors provided feedback on an earlier draft of this report; however, the panel was free to accept or reject this input in preparing this final version which should be considered independent.

Main Findings

Clients and caregivers expressed gratitude for having access to home care but also concerns about service sufficiency and properly qualified staff. They emphasized the need for more

integrated care, how highly they value continuity of care and how both are adversely affected by the competitive bidding process. They expressed a preference for not-for-profit delivery. They raised fears about the consequences of complaining and their concerns about being pushed prematurely into facility care.

Citizens and Public Interest

Groups identified key principles for home care such as respecting client choice and maintaining client independence and dignity, and emphasized the need for greater accountability, transparency and democracy in this sector. The requirement to divest direct service staff was seen as a waste of scarce resources. They criticized the competitive bidding process and its increasing reliance on for-profit agencies, warned about market concentration in the sector, and suggested that it might be time to consider new home care legislation.

Workers found home care work highly meaningful and, although they largely felt appreciated by their clients, they felt unappreciated by the system, citing job insecurity, low wages, and few, or no benefits. They described the negative impacts of casual 'elect-to-work' employment, how the volatility of gas prices was affecting them, of traveling long distances without compensation for their time. While some could not get enough hours others had very high workloads as a result of their agency being short-staffed. Some told about starting over again at the bottom with a new agency having lost any seniority and often for lower wages. They objected to having to sign "gag" orders,

and noted how competition had undermined cooperation among agencies. Many said work in a nursing home or hospital offered better pay, guaranteed hours and more security. They spoke about high levels of stress at work and having to cope with unsafe working conditions. PSWs talked about the high costs of formal training, particularly in private schools.

Labour organizations noted that home care workers often lack the same protections other workers in the province have, pointing out that many have no pensions, no sick pay, no statutory holiday pay, and no right to severance or successor rights. While the vast majority of hospital workers belong to a union, union density in the home care sector is very low.

Labour organizations advocated for a return to card-based certification to help improve the level of union representation in home care. Unions also criticized competitive bidding noting that its impact in driving down wages does not necessarily translate into public savings. For example, when the service volumes of one non-profit home support agency were transferred to five for-profit firms, all but one charged higher prices. The additional revenue, however, was not passed on to workers who, on average, were paid almost a dollar an hour less.

Provider Organizations noted multiple threats to the stability of the home care system including: the challenges of meeting goals with insufficient funding, very high turnover rates, the difficulties of attracting and retaining workers, an aging workforce, the lack of regular hours, large differences in

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the wages and benefits between home care and other health care sectors.

They pointed out the risks of focusing on post-acute care clients (those discharged from hospital) at the expense of those with long term needs and applauded the province's recent decision to remove or raise service caps. They pointed out the absence of a level playing field with one noting, for example, that non-profit employers with a long history who lost a contract were subject to very high severance payouts while the for profit firms, as newcomers relying, in some cases, exclusively on casual labour, had no similar obligations.

They pointed out that prices for home care have gone up since competitive bidding began but that service volumes have declined suggesting that the increased revenues have gone to profits or surpluses not to direct care. The high costs associated with competitive bidding were highlighted especially those associated with preparing bids and monitoring for quality.

System Issues Ontario is the only province relying exclusively on competitive contracting for professional and home support services and the only health sector in Ontario where direct patient care is contracted out, raising questions about the appropriateness of using market mechanisms to allocate home care contracts. Assessing bids and monitoring performance is very costly and involves significant challenges in measuring outcomes reliably and validly, especially when for-profit organizations are permitted to keep much of their information secret. Competition was also described as generating a climate of fear and reluctance to share best practices, and made it harder to attract and retain staff.

Conclusions and Recommendations

Home care needs to be seen as a strategic service, since its adequacy, quality and safety has a direct impact on our system as a whole and its total cost. The home care system described in the public hearings process revealed worried and even frightened clients, exasperated citizen and public interest groups, demoralized workers and a seriously destabilized provider community.

While our report highlights evidence in each of the sections, which along with the submissions from the hearings, give rise to our recommendations, we note the serious need for more research and evaluation of this sector.

The following recommendations do not tackle all the concerns raised but they do reflect the panel's consensus about which are the most urgent and which can actually be implemented within a fairly short time frame.

Clients' Rights:

1. Home Care policy should respect client choice in the decision to receive care at home provided the total public costs for home care do not exceed the total public costs for care in a nursing home or hospital.
2. Ensure that clients are told about their rights to have a case review and to make an appeal if they are dissatisfied.

Addressing citizens' concerns about accountability and transparency:

3. As permitted by the current LHIN legislation, re-establish CCACs as nonprofit organizations, restore their right to select their own boards, and hire their own CEOs.

4. Restore the right of CCACs to hire their own direct service staff where this option offers a more cost-effective alternative.

5. Outlaw gag orders and establish whistle-blower protection so workers can report their concerns about the quality and safety of home care.

Stabilize the workforce to protect continuity and quality of care:

6. As soon as possible, establish wage parity for all professional and personal support workers (sometimes called health care aides) so that new minimum wages reflect the average minimums paid in the nursing home and hospital sectors.
7. Immediately ensure that mileage rates paid to PSWs and homemakers reflect the volatility of gas prices (as well as the costs of wear and tear and vehicle maintenance) and ensure parity in the mileage paid to all workers throughout the home care sector; within 18 months require that all home care workers be compensated for travel time, with the amount of compensation based on a proportion of their hourly rate.
8. Within 3 years, ensure permanent full-time work for at least 70 percent of all home care professionals, PSWs and homemakers
9. Within 3 years, ensure all home care workers are entitled to receive benefits, including a pension plan, health coverage (dental and drugs) and sick pay.
10. Immediately eliminate "elect to work" and ensure that all home care employees receive payment for statutory holidays, notice of termination and severance and create a regulatory requirement for successor rights.
11. Limit the proportion of workers without PSW certification employed by any agency offering home care to a

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maximum of 10 percent of its workforce.

12. Create a special provincial government fund to facilitate the implementation of recommendations 6-11.

To Address System Issues:

13. Given the increasing importance of home care as a strategic service in providing cost-effective care, ensure sufficient funding levels to meet client needs for homemaking, personal support and professional services.

14. Continue to establish province-wide standardized quality indicators, and set multi-year targets for improvement as part of the ongoing performance monitoring of home care delivery, and conduct comparisons of CCACs' performance.

15. Halt all competitive bidding by extending the current moratorium indefinitely and do not issue any new

RFPs until recommendations 6-11 have been fully implemented. In the interim, protect service volumes for those who can demonstrate good employment practices and good quality of care and shift volumes away from those who cannot.

16. To further innovation, encourage LHINs to pilot and evaluate alternative models of allocation, reimbursement, and service delivery in home care. Examples could include Veteran's Independence Program²; PACE³; and Balance of Care⁴; as well as direct service provision by CCACs.

17. Provide government funding to conduct a systematic evaluation of for-profit, not-for-profit and public home care delivery models.

18. Ensure a standardized curriculum for PSW training, an accreditation program for all public and private schools offering the program, and pro-

vide tuition assistance to ensure that home care clients have access to a skilled workforce.

19. Conduct ongoing human resources planning for the home care sector and establish a registration program for PSWs and homemakers so their employment within the system can be tracked.

20. Give serious consideration to the possibility of embarking on a process for legislative renewal in the home care sector. ♦

For more information see the Ontario Health Coalition site at www.ontariohealthcoalition.ca

COUILLARD ETHICS BIG PROBLEM: MDs

A Canadian physicians' group has called into question the ethics of Quebec's former health minister Philippe Couillard. Shortly after leaving government this summer, Couillard joined the company that owns Medisys health group, an investor owned for-profit company that provides health care.

"We questioned Couillard's commitment to universal, equitable health care when he was the health minister," said Medical Reform Group spokesperson Gordon Guyatt. "Couillard's behaviour on leaving office shows that our concerns were well-grounded." As health minister Couillard presided over expansion of investor-owned for-profit health care provision, including companies that charged for insured services, thus violating the Canada Health Act. Couillard

showed no concern, and no commitment to prosecute companies leading the move to two-tier health care. Days before leaving office Couillard expanded the number of procedures that publicly funded providers could outsource to for-profit providers from 3 to 50, also cutting in half their costs for permits.

"The company that Couillard is working for is directly undermining equitable delivery of physician and hospital services" said another MRG spokesperson, Dr. Ahmed Bayoumi. "Couillard's behavior in office violated the public interest. Now he is devoting his entire energies to activities that violate the public interest."

Investor-owned for-profit companies cause problems beyond creating U.S.-style two tier health care. They bleed doctors and nurses from already

over-stretched not-for-profit providers. Furthermore, their charges to public payers are higher and, on average, they deliver poorer care. Studies from the U.S. have shown higher death rates in for-profit hospitals and dialysis facilities.

"The public may wonder why politicians support for-profit health care that undermines equity and in which funds that should be going to care go to profit," Dr. Guyatt concluded. "Couillard isn't the first politician to provide the answer by moving from office to a company that will benefit from the slow destruction of universal health care." "A cynical definition of politics is the conduct of public affairs for private interests. Sadly, Couillard's behavior tells us that cynicism is sometimes warranted." ♦

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FALL MEETING REPORT

On Wednesday evening, September 17th, 2009, Assistant Deputy Minister of Health and Long Term Care, Adalsteinn Brown engaged a lively audience as he outlined ministry plans for a more focused equity strategy to complement the government's eagerly anticipated poverty reduction strategy.

He began his presentation summarizing the current state of access:

- ◆ Canadian women, on average, live six years longer than men but are more likely to have long-term activity limitations and chronic conditions
- ◆ Immigrants generally arrive with better health than the Canadian-born, but this "healthy immigrant effect" tends to diminish with time
- ◆ In 2003, residents of Toronto's poorest neighbourhoods were less likely to report being physically active than those in more affluent neighbourhoods
- ◆ Aboriginal people with end-stage renal disease are half as likely as others with this condition to receive renal transplants
- ◆ In 2004, 21.4% of the Canadian population lived in rural areas, where only 9.4% of physicians (15.7% of family physicians and 2.4% of specialists) practiced
- ◆ In 2003, 22% of Canadian gay men, lesbians and bisexuals reported that they had an unmet health care need in 2003, nearly twice the proportion of heterosexuals (13%)

Brown noted that countless opinion polls have confirmed the interest of Ontarians in ensuring that less affluent and/or those with persistently poor health are not left behind. Strategies include policy change at the primary care level and at the system-level. The review comes in the context of the imminent release

of a provincial poverty reduction strategy where the premier has charged every ministry to make recommendations to improve on what the evidence points to—that low income Ontarians persistently have poorer health than average.

Despite acknowledged variations in access, as noted, the costs of the increased burden of illness create pressure on health system resources, result in suffering for residents of our community, and represent a challenge in the face of our commitments in a range of provincial, federal and international human rights instruments.

Brown proposed a 'joined up' approach to access and equity which integrates disparate access to care and the social determinants of health. In the context of LHINs, and as part of a strategic research initiative, he is in the process of building an Equity Unit within the Ministry to lead health equity initiatives and support equity based approaches to planning. This unit is fostering an emerging methodology, Health Impact Assessments (HIAs), to guard against negative impacts on vulnerable populations. The speaker expressed concern that as they reviewed this part of their strategy, how few HIAs there were which focused on vulnerable populations.

Brown noted that the LHINs share this equity perspective and he enumerated some of their current initiatives, and wrapped up his presentation urging the audience to work together on the 'joined up' approaches in the implementation of the ministry's 2020 Strategic Plan..

Campaign 2000 Coordinator and long-time children's services and child care advocate, Laurel Rothman, led the response to Brown's presenta-

tion. She acknowledged and applauded the Assistant Deputy Minister for his forward thinking. She wondered in particular about other parts of the ministry and other parts of the provincial government, chiding Brown for his lack of consultation with the very active community sector from which she came. Rothman described Quebec success around the much lauded child care initiative which made use of a monitoring mechanism largely run by the provincial voluntary sector in that province. She wrapped her review of the issues raised by noting that in her experience both income and services matter, and we will need to make progress in both to achieve any significant poverty reduction.

Several audience members took up the issue of consultation and accountability and counseled against reinventing the wheel with the new equity unit. There was a lively discussion of tactics that could assist in persuading the public that the government was serious about access and equity and poverty reduction, including:

- ◆ Adapting the system report cards to reflect access and equity
- ◆ Disseminating information more broadly (contents of presentation, opinion survey, among others) to raise the level of public debate

Others confirmed public concern around accountability for public spending and concerns that with the prospect of recession, the most vulnerable not be left behind. Brown agreed, and invited members to keep in touch with him over opportunities for mainstreaming equity and access, encouraging more formal business thinking as advocates made recommendations. ◆

P3 DISASTER DEMANDS CHANGE, DOCTORS SAY (continued)

"The findings are completely predictable," said another MRG spokesperson, Dr. Ahmed Bayoumi. "The P3 mechanism entails huge, unnecessary legal costs, and the private sector's goal – appropriate from their viewpoint – is to make a profit at public expense. Furthermore, private sector borrowing costs will always be greater than government's. The P3 mechanism just doesn't make sense."

Governments have failed to learn from the experience in Britain, where the P3 mechanism was pioneered, with often disastrous results. The British Medical Association has issued dire warnings about the arrangements. "Lots of money has been taken out of the health service" as a result of the way the projects are financed and operated, Dr. Jonathan

Fielden, chair of the association's consultants' committee, has said.

"British governments have persisted with the P3 mechanism long after it became clear it didn't serve the public interest. Hopefully, our Canadian governments will not be so foolish," Guyatt concluded. ♦

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MRG MEMBERSHIP APPLICATION

I would like to ☐ become a member ☐ renew my support for the work of the Medical Reform Group

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Account holder's name (print)

Account holder's signature

Date

STUDENTS FOR MEDICARE PRESENT:

On Saturday, March 28th, 2008, Students for Medicare will host MEDICARE: FROM LEARNING TO ACTION in Toronto.

This one-day conference aims to build the advocacy capacity of health sciences students and residents with a series of guest speakers and workshops which look at the history of Medicare, analyzing critically and responding to popular myths and opponents of publicly funded health care in Canada.

Many Medical Reform Group members who remember Mimi so fondly met her during their training as medical students or residents, and recall what a profound effect she had on their lives and on their careers.

It is this touch that Mimi had, not only on her patients, but also on learners, that we wish to carry on. The spirit of this conference is to pass this spirit of activism that lived in Mimi on to the future health care profes-

sionals of Canada so they too can advocate for patients and advocate for a free and fair health care system for all.

To raise funds for this conference, we are asking members to contribute to making the conference a tribute to Mimi Divinsky. For more information, either on the day-long conference or on how to contribute, contact MRG at (416) 787-5246 or medicalreform@sympatico.ca

STUDENTS FOR MEDICARE is a network of medical, nursing and other health sciences students in Ontario who are working together with other local and provincial advocacy groups to educate themselves, raise awareness, and provide leadership on maintaining and enhancing publicly funded health care in our country..

Here is a testimonial from Ritika Goel, one of the conference organizers:

Reading stories about the past and the loving, heartfelt words written describing her, I regret I never met Mimi Divinsky.

I became involved with the Medical Reform Group steering committee in 2007, the year Mimi died.

At the first Health Providers Against Poverty Special Diet Clinic I attended, a picture of Mimi was held up, and people spoke of their memories of this clearly cherished person whose presence was palpable in the room.

It is my absolute honour to carry her name forward and pay tribute to her life through this conference focusing on educating students, as she so often did, in protecting Medicare, which she so dearly loved.” ♦

**Medical Reform Group
Box 40074, RPO Marlee
Toronto, Ontario M6B 4K4**

*Please visit and comment on our web-site at <http://www.medicalreformgroup.ca>
Please also make a note of our current contact information as follows:
(416) 787-5246 [telephone]; (416) 352-1454 [fax]; medicalreform@sympatico.ca [e-mail]*