

Medical Reform

Newsletter of the Medical Reform Group

Issue 155

Volume 31, Number 2

Fall 2011

PRIMARY CARE REFORM: WHERE WE ARE NOW AND WHERE WE NEED TO GO

We sat down in late summer with Dr. Rick Glazier, a family physician at St. Michael's Hospital and researcher at the Centre for Research on Inner City Health (CRICH). Dr. Glazier's research focus has been in primary care models as well as equity in health care delivery. He discusses the impact of the implementation of new primary care models (FHOs, FHNs, FHTs, FHGs) and how these models could better ensure equity of access to care for underserved populations. The interview with Dr. Glazier (RG) was recommended to us by Dr. Ahmed Bayoumi, an MRG member and colleague at CRICH.

Can you tell me a little about yourself as a background to how you came to do the work you are doing here and now?

RG: Well, I graduated from medical school here in Ontario, and practised briefly as a family doctor in another town before heading off to the Johns Hopkins preventive medicine program. That led me to spend some time with the WHO in Geneva on a program on improving children's survival rates, and then did some consulting on related issues. When I returned to Canada in 1991, it was to the Wellesley Hospital. It's gone now, but it was an exceptionally interesting place at that time, a real community hospital centred around a large gay community at the beginning of the AIDS epidemic. But just next door was St. Jamestown, very dense and home to lots of young families and immigrants. Just a little further south was Regent Park, one of the first large public housing projects in the country,

and just to the north Rosedale, older and with fewer immigrants, which also viewed the Wellesley as their local hospital.

For me fresh from Johns Hopkins and Geneva, the population profiles were particularly striking—where else do you find such a large population of men 20-55, right next to large, young families beside large numbers of low income families, and then just to the north, a much older and predominantly white crowd? This was a ready-made research project, seeing how the hospital dealt with the health needs of such diverse groups.

Q: I understand one of your major current research projects has to do with the most recent stage of primary care reform and the lessons of organizing family doctors in family health teams?

RG: I have had support from the CIHR and have also been working with the provincial ministry of health to assess what has happened

(continued on page 3)

INSIDE

Editorial Notes

There continues to be reason for hope and concern.....2

Closing Libraries

Toronto mayor's approach to balancing the budget short-sighted..6-7

Pre-Election Survey

Some information in this issue to help Ontario members sort out the main party positions.....7-10

Double Standard on Asbestos

Trade trumps health risks.....11-12

Medical Savings Accounts

Not a cure for shortfalls in funding.....12-13

P3s/AFPs in Ontario

Ontarians will still pay...P3s and AFPs are not the answer.....13-14

Health for All

Understanding the problems with unequal access to insurance coverage in Canada.....14-16

Please visit our website at: <http://www.medicalreformgroup.ca>

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

MEDICAL REFORM is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at \$60 per year. Arrangements to purchase multiple copies of individual newsletters or of annual subscriptions at reduced rates can be made.

Articles and letters on health-related issues are welcomed. Submissions should be typed, or sent by e-mail to medicalreform@sympatico.ca.

Send correspondence to:

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 those of the Medical Reform Group.

Editorial committee this issue: Ritika Goel, 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

By the time you receive this newsletter, the 2011 Ontario election campaign will be in full swing. By the end of October 6th when the election happens, some of the pieces of the puzzle around future funding for health care in our country will begin to fall into place. It is likely our work to defend publicly funded health care for all will continue to require all the energy we can give it.

As in previous elections, the Steering Committee was interested to see how the parties stacked up on the major questions relating to health care. See the summary of the major party responses in this issue, and look forward to updates on our website, especially if the conservatives respond. We hope this information will be useful as you probe with your candidates.

As noted in the previous issue of the newsletter, our current federal government is keen to shift as much responsibility as it can to the provinces and territories, and its potential success in that endeavour will depend on the likely reaction it will get from the most populous province.

There is reason for both optimism and concern particularly as we look at the research resources available to help us reinforce our arguments for high-quality publicly funded care.

In this issue, our interview with Dr. Rick Glazier provides a glimpse at the current state of primary care reform in Ontario. He notes progress where that has happened and offers some timely advice to improve access, and if appropriately implemented, with the potential for savings—in money and in quality of care. This is in stark contrast with the OMA's July 21st recommendation to expand private surgery opportunities.

Although only a small minority of our members live or work in Toronto, I think many have been watching our current mayor with interest as he rewrites history (recasting the municipal surplus left him by his predecessor as wasteful spending) and attempts to reduce revenues without reducing services. I for one would have been happy not to see my property taxes reduced by 20% since 2009 and be reassured that libraries, public health, community services and recreation services continue to be available for all who need them.

On the poverty front, I think there are two items that should not escape our attention. Check the August 25th, 2011 issue of the NEJM for a US perspective on the effects of Medicaid coverage on access to services by low income Americans—the so-called Oregon experiment. And back in Canada, one important proposal to the ongoing Social Assistance Review Commission is for a Housing Benefit to be phased in in a manner similar to Ontario and Canada Child Benefit. Food for thought indeed. Look for more on these issues next time. ♦

PRIMARY CARE REFORM (continued)

with the primary care reform and in particular the shift to the use of family health teams. The main interest of the government was to improve access to primary care, after observation of a couple of generations of organizing practice in Family Health Groups, Family Health Networks, and more recently Family Health Teams.

Generally these have been taken up well outside the GTA, but less effective within the GTA. Because the government wanted to get better uptake among GTA doctors, we have been looking at the factors influencing that; in short who is migrating to the new PC forms, what are the consequences for access to primary care, etc.

RG: So we compare the largely fee-for-service forms--these are a bit blended but primarily fee-for-service, one form is primarily capitation, but generally they have the same incentives and same requirements.

So our hypothesis was that--we were thinking that in capitation, doctors need to be paid more to move to capitation. At the time, there was a document you needed to sign, it was more than a hundred pages, it was legalistic, there were a lot of barriers, people were very suspicious about moving from fee-for-service because fee-for-service is very transparent. You see so many patients, you put in so many bills, you do the math and see what you should be paid.

But something where you're being paid per head or per person per year rather than per visit, people were a little leery of whether they can switch back and whether they'd be fairly reimbursed. In the end, I think the experience was that people's income went up a lot, and in fact there's been a publication, Mike Green published a study at Queen's suggesting that. He actually linked tax

returns for consenting doctors where he found income went up about 30% for people who joined. So it was big and the ministry knew it had to pay more to get people to do these models. When we compared the groups that were family health networks, the capitation ones with those that were remaining in fee-for-service but were otherwise in similar models, we found that the capitation plans had lower proportions of low-income populations, lower proportions of immigrant populations and had overall healthier populations and had overall higher emergency department visits.

And we got very concerned when we saw the pattern of emergency department visits, and even after we controlled for urban-rural and that kind of thing, and we went back and said "Did these same groups have high emergency department visit rates before they became these family health networks?" And they did. So it wasn't that going into capitation made the rates go up, it's that groups with higher rates moved into these groups. So the headline, the André Picard headline was "More doctors for the healthy and wealthy," And that is in fact more or less what we found at the time.

Since that time, I've got a CIHR grant, and also there is the work that we've been asked to do by the ministry to look at the family health teams. The majority of physicians now are in a similar model to a FHN called a FHO, family health organization, and it's actually more popular now than the family health group, because I think of the higher incomes. As in the family health network, the incomes have gone up a lot in the family health organizations in that model, and you have to be in one of those plans in order to be a family health team, in order to get all the resources

of an interdisciplinary team and the electronic records, you can't be in fee-for-service, you can't even be in this enhanced fee-for-service, you have to either be on salary or one of these capitation plans.

From an equity perspective, we've actually found the same thing. We haven't published this yet but in the ministry reports and the internal work we've done, the same phenomenon occurs for the family health organizations and the family health teams, because they're comprised largely of these capitation plans. It's the exact same phenomenon where it really looks as though the case mix is not as high or the patients are not as sick as in the family health groups, that they're under-serving low-income populations and that they're under-serving immigrant populations.

None of that was by plan, these are all unintended consequences, but there are a few features--I'll get into a bit of detail--but one of the big issues here is that other capitation systems in the world realized that it's not a level playing field and that practices are very different. In Ontario they adjust for just age and sex. Somebody who is older, you get more money for than somebody who is younger, for example. Thinking that they're going to make more visits, going to have more health care needs as they age, but it's a pretty crude thing. Young people can be sick and older people can be very healthy, so they're thinking that if you have an average practice, we'll reimburse you according to the age and sex distribution of the practice. Unfortunately what that does is it sets up an incentive for healthier practices to move into these plans because there's a greater financial benefit for them.

As it's turned out, a lot of

(continued on page 4)

PRIMARY CARE REFORM (continued)

practices outside of Toronto and other large cities, ie largely suburban practices have an average kind of profile, or a healthier profile, and for them the ministry used to provide a revenue analysis, which would give the percentage increase you could expect if you go into one of these capitation plans, so they have perfect hindsight, or perfect foresight to be able to say “if my income is going to go up 30-40%, I think that’s awfully attractive, and it’s worth taking this risk and signing this document. If my income is going to only go up a few percent or is going to go down, I’m not going to bother, I’ll stay where I am.”

So I think that’s what actually happened to attract these healthier, wealthier practices with their healthier, wealthier patients. Because there wasn’t much uptake in Toronto of these models initially, that’s why immigrants have not been represented so much, because they’re way over-represented in the GTA and GTA physicians were not that interested.

There’s another phenomenon too, there’s no adjustment for how sick your patients are, and almost every other capitation model in the world either controls the socio-economic status, so in the UK they have a deprivation index, so you control either for socio-economic status, knowing you’re going to identify higher needs populations, or you actually measure how ill your population is, and there are systems like Johns Hopkins’ case mix adjustment system that we’re proposing using, that Medicaid and Medicare in the US use and other countries use, to adjust capitation payments.

Some of the stories that you hear about doctors interviewing patients and screening out sick patients, there’s not much need to do that in fee-for-service, because you can just

have them make more frequent visits if they’re sicker. In capitation, if you’re being paid a flat fee, say, about \$130 which is about the average, to look after someone for a year, and you know by looking at them and understanding their medical history, they’re going to make 10 or 20 visits a year, you don’t want them in your practice if it’s a capitation practice.

Then we have an additional phenomenon, it’s getting a bit more into detail here, that doctors also lose dollar for dollar up to 20% of their income if their patients see doctors outside of the group, primary care doctors outside of the group, this is something that’s misnamed but is named the access bonus. So in the GTA, the larger urban centres, Ottawa, Hamilton, the GTA, there are a lot of options, you can go to a walk-in clinic, an after hours clinic, you can go to a sports medicine therapist, you can get your veins stripped by a family doctor, etc.

If any of those services you get are inside the basket of services that the doctor’s already being paid capitation for, they lose up to 18.5% of the capitation payment, but it’s called a bonus, so they lose the bonus. But when we look across the province, the doctors losing the bonus are in the GTA, and paradoxically, the emergency department rates are the lowest in this area and they’re high across the rest of the province. So we’ve got this paradoxical phenomenon where the system has quite inadvertently provided this incentive for doctor’s to send their patients to the emergency department rather than walk-in clinics because they don’t lose any money, so the patient goes to the emergency department. And it’s paradoxically set up, these new systems with all the family health teams in areas of lower need on average rather than in areas

of higher need. So that’s more or less what’s been going on. These are not dramatic differences, there are family health teams in areas of need, there are capitation models in areas of need, there are fee-for-service in areas with healthy patients, for example, but there’s a small difference, and in any time frame that we’ve looked at we found the same thing, any part of the province we’ve looked at, we found the same thing.

Q: What I wanted to move a little bit toward is your feedback on – we’re coming up to another provincial election, we just had a federal election, people are complaining about how we’d have to look at new models because people like you and me are getting older and using the system more, so I guess I’m trying to figure out what are the implications of your research, where that 2, 3, 5% does make a difference down the road?

RG: It’s true. I would say that building these interprofessional teams, getting doctors off fee-for-service, building these interprofessional models of care is absolutely necessary to organize the health system. The primary health care part of the system has been completely entrepreneurs setting up where they want, doing what they want, it’s not really had any government structure, it’s had very little accountability, practitioners just do what they want, it’s been a very laissez-faire kind of system with little coordination with other parts of the system, like the hospital sector or long term care or community care. And if we’re going to have a rational system, all that has to change, it has to be much better organized.

These inter-professional teams are a good step in that direction, they have governance models, they have accountability agreements, they are

(continued on page 5)

PRIMARY CARE REFORM (continued)

accountable for certain things. Community health centres have long had agreements and accountabilities and are in fact accountable to the LHINs right now, so we will have LHINs after the election. But these steps are not sufficient. They're necessary but no steps have really been put in place to ensure better access and we don't have any measure, this incremental large investment was meant to improve access first and foremost.

Also we have no measure of access in the last 5 or 6 years that's actually improved. Emergency department visit rates have stayed the same, walk-in clinic rates, percent of people who can see a doctor or a nurse in the same day or next day when they're sick, the percent who can see somebody after hours without calling the emergency department, it's all been very – the percent of the population without a family doctor, it's all been very very static over the past 5 or 6 years, despite these investments. I think there's been an inadvertent, the incentives were not designed this way, but inadvertently, if you've put most of the resources in to not looking after the more disadvantaged and sick populations, and there are perverse incentives to send people to the emergency department rather than necessarily having them looked after in community settings, then it's not that surprising in hindsight that we run into these problems. And there are only so many providers, you can't change the provider pool that quickly, so this all takes time. And the population, in fairness, the size of the population grows every year and gets older and the number of providers also is changing but probably not rapidly enough.

Q: So it just occurs to me to ask, you are talking about the population demographics, what about the

provider demographics?

RG: Yeah, providers are getting older, a lot are pushing retirement age, and then the demographic in family medicine especially is that a lot of new family doctors are women and they are taking time to have children and to spend with their families. But there is pretty good evidence that male family physicians aren't willing to work the 50-60 hours that their predecessors were either, so people are a little bit more attuned to having a life or doing the things in life other than just medicine.

Q: So if you were going to fix things, how would you go about it?

RG: Well we're working with right now with a joint ministry-OMA sub-committee on a system to adjust capitation payments for patient need. And I think that would be a tremendous step in the right direction. And both sides agree in principle that they're coming up to a difficult negotiation right now that involves money. And the ministry has said of course there's no new money and they're trying to figure out how there's going to be more money.

Q: Is this something we want to try and sort out before the next provincial election?

RG: Well I would like them to and we're presenting it in a few weeks to the Physician Services Committee, with the idea that if you adjust practices for need, how does it look different than just age and sex. If there are winners and losers when you're looking after a very healthy population you might get paid less, or looking after a very sick population you might get paid more. If you're looking at a very sick population and before you couldn't think of going into one of these plans, now you might because there's a different incentive, and you might be able to get

resources like in a family health team to help you look after these very sick populations, where now you can't. So that's one direction.

A second direction is this whole access bonus thing, I think needs to change dramatically. Some measure of actual patient access to care would be much better, whether these are practice based surveys or some other method or third next. They have this measure called third next available appointment which is how soon can your patients see you when they want to, if they want a same day or next day appointment. If your third next available appointment is in three weeks, they're not going to be able to get timely access to necessary care. Doing something about providing some strong positive incentives for doctors to be available and to make same day and next day availability needs to be a priority.

Then, the third thing is that we always need services targeted, we need general services aligned to the needs of more disadvantaged populations but we still are always going to need targeted services. The expansion of CHCs is very definitely in that right direction and they have been expanded, so CHCs, there are 26 nurse practitioner-led clinics. We need to have a large expansion of targeted services that would include CHCs, the NP-led clinics, they've announced a child and youth mental health strategy that will involve a roll out of new and additional services over time. And there are aboriginal services, francophone services, there are all kinds of services that need to be targeted to high needs groups, regardless of what you do for the general population and how you align it, you still need specific strategies for these harder to reach groups.

(continued on page 6)

PRIMARY CARE REFORM (continued)

Q: I wonder at what cost, what other things can we do?

RG: The other thing I will say is that there were a series of meetings over the last year or two that were national or international in scope about high performing health systems. The best models out there in primary care are for sure very different from ours. And accountable care organizations in the US that are falling under the Obama health care plan, if that succeeds and moves forward, they've been designed to have all these features.

So one of these features is for them to constantly measure performance.

Another is for them to publicly report that performance; yet another is to become patient-centred and community-engaged in how they do their work. So we've got all of these things that will lead towards these very

high performing health systems. We have a lot of patient engagement, a lot of patient input, they constantly measure and improve and they constantly measure and improve and they undertake these quality improvement initiatives on a constant basis and they have teams of health professionals, professionals that have job descriptions like "System navigator," "Patient advocate", "Outreach worker", because the traditional health system is not very good at chronic disease, multiple chronic disease, mental health, and people just fall through the cracks, can't navigate the system. So when I look at where do we need to go, not just for aging population, but if we're really going to be patient-centered, people are going to get appointments when they want them, not when doctors find it convenient, they're going to be heard and their needs are going to be met in very

different ways and the system will be constantly measured and improved. And that's a really radical change from now, we're a long way from that.

Q: And how much does that cost?

RG: Well really the thing is that there are tremendous savings. The systems that have done it have halved their emergency department and admission rates, there are way bigger savings to be had, because those other sectors are hugely expensive and the primary care sectors are not. So there are enormous savings to be made in the system by implementing really strong community-engaged primary healthcare, tremendous savings. It's really the only sector you can invest in that could at the same time improve quality, improve population health and reduce costs, the so-called triple game. ♦

CLOSING LIBRARIES BAD FOR YOUR HEALTH SAYS DOCTORS' GROUP

The Medical Reform Group (MRG) today called upon Toronto City Council to keep Toronto public libraries open, noting that literacy is an important social determinant of health.

Earlier in the week, Toronto city councillor Doug Ford, a close ally of his brother Mayor Rob Ford, was quoted on a radio talk show as saying that there were more libraries than Tim Horton's donut stores in his ward.

"Contrasting libraries and donut stores is useful for illustrating how public investments can have important downstream consequences," noted Dr. Gordon Guyatt, an MRG spokesperson.

"A triple chocolate donut has over 300 calories and 10 grams of fat" noted Dr. Michaela Beder, another MRG spokesperson. I looked it up on the internet. That's the kind of useful health information you could find at a library. Eating many donuts is unquestionably unhealthy, but reading many books might actually improve your health."

Beder quoted a 2004 review commissioned by the United States Agency for Healthcare Research and Quality that demonstrated that individuals with low literacy levels were 1.5 to 3 times more likely to have poor health outcomes than individuals with high literacy levels. "That is a large and important effect," noted

Beder. "Addressing low literacy has been recognized by the Canadian Public Health Association as a priority." About 48 per cent of adult Canadians have low literacy, particularly seniors, immigrants, and people living in poverty.

Guyatt noted that rates of low health literacy – the ability to read and understand health information – are likely even higher than rates of low general literacy. A review published in July showed that, among elderly individuals, low health literacy was associated with 27 to 50 per cent higher mortality rates. "Libraries are an essential source of knowledge, including health information, and of-

(continued on page 7)

CLOSING LIBRARIES BAD FOR YOUR HEALTH (continued)

ten one of the few ways for people living in poverty to access books or the internet,” he remarked. “It’s time for all levels of government to recommit to investing in upstream determinants of health, such as ad-

ressing low literacy and reducing poverty.

“The day we actually do have more libraries than Tim Horton’s, it will be time to celebrate. In the meanwhile, we have to defend To-

rontonians from ideologically motivated cuts to essential services.” ♦

Released by the Medical Reform Group on August 3, 2011.

PRE-ELECTION SURVEY ON HEALTH CARE ISSUES

With the fall Provincial Election looming, the MRG decided to contact our three major provincial parties to get their take on health care issues. Despite information on party websites, there often was not enough detailed information to answer questions MRG members may be interested in seeing answers to.

We sent a letter to each party asking specific questions related to public-private partnerships (P3s), Local Health Integration Networks (LHINs) and poverty reduction as a key strategy for improving health of our society. The letter we sent as well as a compilation of their responses follows (Note: We received no response from the Ontario Progressive Conservatives Party despite multiple attempts at communication, so their information is collected from their public website). Watch our own website for any updates.

I am writing on behalf of the Medical Reform Group, a voluntary association of physicians and medical students. For over 30 years, the MRG has promoted social justice and health, including advocating for publicly-funded health care for all Ontarians. In view of the pending provincial election, we are seeking your feedback on three important issues. Your response will help inform our members and friends about the approach of your party to some of

the critical health-related questions in Ontario today.

Two of our questions have to do directly with health care delivery in the province:

1] What is your party’s approach to providing the necessary health service delivery capacity to address our current needs? In particular, what role do you see for public-private partnerships?

In the recent past, governments at all levels have sought partnerships with the private sector (P3s or more recently AFPs) as a strategy for augmenting or replacing health infrastructure. However, considerable evidence indicates that such partnerships make it more, rather than less, difficult to maintain accountability around costs. As well, cost overruns almost invariably result in increased borrowing costs relative to public projects because of the preferred government credit rating. Please comment on how your government will approach funding, including the use of P3s.

2] What is your assessment of the success of the system of Local Health Integration Networks? How would you change the structure of LHINs and to improve health service delivery to Ontarians? Like other Canadian provinces and territories, Ontario has moved to a regionalized model of service planning with the expectation that regional authorities can be

more responsive to local needs and conditions. Please comment on how your party would approach regionalization of health services delivery, including plans for governance and community representation.

The other question addresses some broader health determinants and the potential for policy leadership upstream to address the sustainability issues that are on the minds of many voters.

3] What specific measures does your government anticipate leading, if elected, to address the persistence of poverty and its consequences on health in Ontario? Poverty is a major cause of ill health. With a lot of encouragement from advocates, the McGuinty government made an initial attempt to address this issue by passing poverty reduction legislation in late 2008. This legislation anticipated a 25% reduction in child poverty by the end of their current mandate. Please comment on what goals your government would endorse and plans you have to reach these goals.

I look forward to a response from you by Monday, August 22nd, so that we can pass the information on in good time to our members.

Yours sincerely,
Dr. Ritika Goel, for the Medical Reform Group.

(continued on page 8)

PRE-ELECTION SURVEY ON HEALTH CARE ISSUES (continued)

	<p>1. What is your party's approach to providing the necessary health service delivery capacity to address our current needs? In particular, what role do you see for public-private partnerships?</p>
Ontario Liberals	<p>Ontario Liberals are committed to a strong publicly funded health care system. That is why we banned American-style two-tier medicine by passing the Commitment to the Future of Medicare Act. We shut the door on extra billing, queue jumping and user fees.</p> <p>Since 2003 we have repatriated privately run for-profit MRI clinics into the non-profit system and focused on rebuilding the public health system, which had been chronically under-funded under the Harris government.</p> <p>We have significantly reinvested in the capital stock of the health care system. Infrastructure Ontario has delivered many of our hospital infrastructure projects under the Alternative Financing and Procurement (AFP) model, which leverages private-sector expertise to deliver complex infrastructure projects on time and on-budget. Yet all of our hospitals — even the ones built using the AFP model — are publicly owned, publicly operated and publicly accountable. In AFP projects, private-sector partners handle aspects of project design, construction, financing and maintenance. However, the private sector never touches the patient.</p> <p>Ontario Liberals are committed to delivering the very best health care at the best possible price. That is why, before a project goes forward as an AFP, a comprehensive and independently reviewed value-for-money assessment must show that the AFP is the best approach. These value-for-money assessments are publicly posted on Infrastructure Ontario's website, and they show that projects completed to date have generated more than \$500 million in value-for-money savings.</p>
Ontario Progressive Conservatives*	<p><i>No specific mention of strategies for new health infrastructure, public-private partnerships or alternate financing and procurement in changebook.</i></p> <p>We will introduce a series of patient-centred reforms that make the patient—not the bureaucracies, not administrators—the focus of our health care system. We will increase annual investments in health care by more than \$6 billion by the end of our first term.</p>
Ontario New Democratic Party	<p>The Ontario NDP has opposed public-private partnerships in healthcare since their inception. These partnerships have cost Ontarians hundreds of millions in cost overruns and have resulted in hospital projects that deliver far less than originally promised. Ontario's Auditor General, in his 2008 report, exposed the significant problems of this model, yet the McGuinty Liberals have continued to support it. The Ontario NDP fully supports the position of the Medical Reform Group and would immediately end a P3 funding scheme so that infrastructure and healthcare dollars are directed at serving Ontarians rather than squandered on these wasteful private deals.</p>

(continued on page 9)

PRE-ELECTION SURVEY ON HEALTH CARE ISSUES (continued)

	<p>2. What is your assessment of the success of the system of Local Health Integration Networks? How would you change the structure of LHINs and to improve health service delivery to Ontarians?</p>
Ontario Liberals	<p>Ontario Liberals believe that local planning and decision-making improves the quality of local health care. In a complex \$45-billion public health system, it is vital that those who know what is happening in communities are empowered to make decisions and allocate resources. Running the provincial health system from Queen's Park is simply not a credible alternative.</p> <p>That is why in 2005 we moved to devolve health care decision-making closer to the community. We established Local Health Integration Networks (LHINs) to plan, fund and integrate services at the local level. Since their inception LHINs have been vital system partners in improving health provider accountability and financial performance. LHINs have helped us end the annual cycle of multi-hundred million-dollar hospital deficits and bailouts that were commonplace under the previous government. LHINs have also led efforts to move care to the community through the province's Aging at Home Strategy.</p> <p>Ontario Liberals believe that we need to move forward instead of backwards. LHINs have taken important steps to improve community decision-making in health care. They have served as a catalyst for decisions to integrate care across the acute and community sectors. Patients are benefiting through improved access to service, higher quality care and lower wait times.</p> <p>We need to build on this foundation to move even closer to a truly integrated care system that benefits patients — particularly the frail elderly who often fall between the cracks of different individual providers. We will look for ways to integrate additional services into regional planning structures and will empower local networks to move more care into the community.</p>
Ontario Progressive Conservatives*	<p>...the LHINs are unelected, unaccountable, faceless bureaucracies that the Dalton McGuinty Liberals hide behind whenever there are beds to close, emergency rooms to shut, or nurses to lay off. To date \$300 million health care dollars have been diverted from frontline care to pay for salaries and administration. We will close the LHINs and redirect those dollars to patients.</p>
Ontario New Democratic Party	<p>Local Health Integration Networks (LHINs) were supposed to bring a community voice to health care planning. Instead, these unelected, unaccountable bodies have forced significant changes in local health care services without any meaningful consultation. An investigation by Ontario's Ombudsman found that the LHINs had even violated the law by holding illegal, secret meetings to hide decision-making from the public. We will scrap the LHINs and replace them with effective, local decision-making. We will engage Ontarians in a collaborative, democratic process that will facilitate genuine dialogue in order to develop a new model for local healthcare decision-making.</p>

(continued on page 10)

PRE-ELECTION SURVEY ON HEALTH CARE ISSUES (continued)

	3. What specific measures does your government anticipate leading, if elected, to address the persistence of poverty and its consequences on health in Ontario?
Ontario Liberals	<p>Ontario Liberals are working hard on behalf of low-income Ontarians and will continue to make poverty reduction a priority going forward. In 2008, we released the province's first ever Poverty Reduction Strategy, with a target of reducing poverty by 25 per cent by 2013. To enshrine this commitment into law, we passed the <i>Poverty Reduction Act, 2009</i> to ensure that successive governments remain focused on the fight against poverty. We remain committed to the goals outlined in our strategy, determined to continue to build on our successes, and will develop a new strategy in accordance with the <i>Poverty Reduction Act, 2009</i>. As part of the Poverty Reduction Strategy, Ontario Liberals are delivering programs and services that are making a real difference in the lives of low-income Ontario families.</p> <p>The Ontario Child Benefit is providing up to \$1,100 per child per year to over one million children and is allowing families to move from social assistance to employment more easily. Full Day Kindergarten is saving families thousands of dollars per year on child care costs. We have increased the minimum wage to \$10.25, increased social assistance rates seven times and have launched the largest review of social assistance in 20 years.</p> <p>Our efforts are getting results. A single mother with a small child working full-time at minimum wage has seen her income increase by \$10,500 since 2003. Despite the worst global economic downturn in recent memory, child poverty levels decreased in Ontario from 2008 to 2009 — meaning that 19,000 fewer Ontario children were living in poverty.</p>
Ontario Progressive Conservatives*	<p><i>No specific mention of poverty or poverty reduction changebook.</i></p> <p><i>The focus of the platform is on lowering taxes for middle class families. This would be done through several measures, including income sharing on for up to \$50,000 of their taxable income and lowering income taxes on the first \$75,000 of taxable income for all earners, as well as tax credits for specific groups, like families caring for a loved one in their own home. Additional measures include the elimination of eco-taxes on items like consumer electronics, light bulbs, and batteries; removing HST from energy bills.</i></p> <p><i>The other focus of changebook is on job creation by reducing corporate taxes to 10%.</i></p>
Ontario New Democratic Party	<p>The Ontario NDP understands that any plan to move Ontario forward must include a strong poverty reduction strategy. We also recognize that poverty is a major determinant of health. That is why the NDP's plan for our province includes strong anti-poverty measures as well as a healthcare plan that addresses the social determinants of health.</p> <p>Our immediate, practical steps to eradicate poverty include: increased Employment Standards enforcement to protect people's rights on the job, reducing the clawback of social assistance benefits from people with disabilities when they're moving back into a job, and ensuring Ontario Works rates keep pace with inflation. We will also increase the minimum wage to \$11 this year and index it to the cost of living so that people who work full-time aren't trapped in poverty. In addition we look forward to following through on the recommendations of the Commission for the Review Social Assistance in Ontario which are expected in 2012.</p> <p>Addressing persistent poverty in our province is not only the right thing to do, it is essential for bringing healthcare costs under control. Our plan for health care includes targeted investments that will address the social determinants of health and improve access to healthcare for all Ontarians. The creation of 50 new family healthcare clinics, based on the successful models of community health centres and nurse practitioner-led clinics, will be staffed by a diversity of providers. These new clinics will offer a range of primary care and health promotion services in order to address the social determinants of health and work alongside diverse communities to improve their health.</p>

Despite 2 acknowledged fax and 3 telephone messages to the office of Opposition Leader Tim Hudak between August 12 and 31, 2011, no information was received from the Ontario Progressive Conservative Party. Information for this chart was extracted from their 2011 platform *changebook*. ♦

THE DOUBLE STANDARD: WHY CANADA CONTINUES TO EXPORT ASBESTOS

It is a shameful reality that Canada continues the export of the hazardous substance asbestos to low and middle income countries around the world. Ritika Goel explores the evidence on asbestos and the interests involved in maintaining this industry despite widespread opposition.

Most people know that asbestos is bad for your health. You may have heard of it as the material once used in fire blankets and insulation, now being systematically removed from our public buildings due to its health effects.^{1,2} What you may not know is that Canada is one of the world's largest exporters of asbestos to low and middle income countries, despite ample warning and condemnation from health professionals, concerned citizens and other nations.^{2,3} Not only are we shamelessly continuing in this practice, Canada is actively fighting regulation of asbestos on a global scale, while attempting to increase our production and export of this known carcinogen.¹

According to the World Health Organization (WHO), "all forms of asbestos are carcinogenic to humans," and lead to over 107,000 deaths every year worldwide from occupational exposure.¹ The WHO estimates that about 125 million people are exposed to asbestos as an occupational hazard worldwide, and one in three occupational cancer deaths is due to asbestos.¹ Beyond this, the organization also estimates that several thousands of deaths each year can be attributed to household asbestos exposure.¹ According to the WHO, "the most efficient way to eliminate asbestos-related diseases is to stop the use of all types of asbestos."¹ Does this sound like a product we want to propagate the use of?

While asbestos has many useful properties such as its extraordinary tensile strength and flame

resistance, its health effects clearly outweigh the potential benefits.¹ So why are our leaders actively defending the exposure of Canadian miners and workers to this substance and how are they justifying its continued use?

One of the major arguments from the government and asbestos lobby comes from differentiating the two forms of asbestos – chrysotile (white asbestos) and crocidolite (blue asbestos, also called amphiboles).¹ Prime Minister Stephen Harper, stated recently, "Chrysotile specifically is permitted internationally under conditions of safe and controlled use,"² implying there is no health concern from the use of this material or any conflict of interest in our export of it. The Chrysotile Institute, formerly the Asbestos Institute, an industry lobby group, states, "Amphiboles are fundamentally different from chrysotile, the latter being less dangerous according to the best scientific studies."⁴

What Stephen Harper doesn't publicize is that Canada has blocked the United Nations repeatedly from adding asbestos to a UN treaty called the Rotterdam Convention, which lists hazardous substance.⁵ We did so again most recently in June 2011, joined by only three other nations – Vietnam, Kazakhstan and Kyrgyzstan.⁵ Not only are we preventing appropriate regulation of this material behind closed doors, but our Prime Minister went so far as to visit one of our two asbestos mining towns, Asbestos, Quebec, as a campaign stop in the recent federal election to gain local support.^{5,6}

In 2010, the Canadian Public Health Association, the Canadian Medical Association and the National Specialty Society for Community Medicine (NSSCM) made a joint call to the Canadian government to stop the mining and export of asbestos.³ "It's inconceivable that we would restrict the use of asbestos in our own country but continue to export this hazardous product around the world," said Dr. Anne Doig, President of the Canadian Medical Association.³

Workers' groups and activists in India, one of the major importers of Canadian asbestos, have said that it is not possible for asbestos to be used safely in India.⁷ The secretary general of the Trade Union Centre of India claimed that at least 20 per cent of workers in India are exposed to asbestos on a regular basis and it is responsible for ill health effects in many of them.⁷ Indian activist uttered the powerful words, "It will be remembered as an act of barbarism in the history of industrial development where asbestos was knowingly allowed to be used, and where workers were knowingly subjected to it."⁷ In 2010, Quebec asbestos exports to India approximated \$427 million.⁷

As though the current production and export of asbestos isn't bad enough, a consortium known as Balcorp Ltd. is actively attempting to buy the Jeffrey Mine in Asbestos, Quebec to increase its production.⁸ The Government of Quebec plans to guarantee a \$58 million dollar loan to Balcorp which will allow the Jeffrey Mine to operate for the next 25

(continued on page 12)

THE DOUBLE STANDARD (continued)

years.⁸ The government has stipulated that Balcorp Ltd. must raise \$25 million from the private sector before they will receive the \$58 million dollar bank loan guarantee, but have extended the deadline twice now, setting it most recently to October 1, 2011.⁸ On an interesting side note, it was recently revealed that the head of Balcorp Ltd., Baljit Chada, hosted a fundraiser for the Quebec Liberal Party.⁸

So now we see how the math adds up. We spend millions of dollars to remove asbestos from parliamentary buildings and the prime minister's own home to avoid ill health effects for our government leaders.⁶ At the same time, we're willing to spend millions more to revive a mine to produce the same deadly carcinogen⁸ which we will send to harm workers and citizens overseas in blatant opposition to science, health and justice. The Canadian government has decided that these costs are worthwhile, but Canadians know better. Show the government how you feel about this deadly practice by speaking out against the production and export of Canadian asbestos now. ♦

References

1. World Health Organization. (2010). Asbestos: Elimination of Asbestos-Related Diseases Factsheet No 343. Retrieved from <http://www.who.int/mediacentre/factsheets/fs343/en/index.html>
2. Benzie, R. (2011, April 26). Harper defends asbestos exports despite cancer risks. *The Toronto Star*. Retrieved from <http://www.thestar.com/news/canada/politics/article/980449--harper-defends-asbestos-exports-despite-cancer-risks>.
3. Canadian Medical Association. (2010). Canada still one of world's largest exporters of Chrysotile asbestos [Press Release]. Retrieved from <http://www.newswire.ca/en/releases/archive/June2010/30/c9363.html>
4. Letter to the European Commission. (November 2010), Newsletter from the Chrysotile Institute For the Safe and Responsible Use of Chrysotile. 9, 2. Retrieved from http://www.chrysotile.com/data/Bulletin_V9_No2-Ang.pdf
5. Rennie, S. (2011, June 22). Canada blocks asbestos from hazardous chemicals list at UN Summit. *The Toronto Star*. Retrieved from <http://www.thestar.com/news/canada/article/1013166--canada-blocks-asbestos-from-hazardous-chemicals-list-at-un-summit>.
6. Cheadle, B. (2011, April 26). Harper defends support for asbestos in Asbestos. *iPolitics.ca* Retrieved from <http://ipolitics.ca/2011/04/26/harper-finds-friendly-locale-to-defend-support-for-asbestos-asbestos-que/>
7. CBC News. (2010, February 1). Indian workers rebuke Quebec over asbestos. *Canadian Broadcasting Corporation News*. Retrieved from <http://www.cbc.ca/news/canada/montreal/story/2010/02/01/india-criticizes-quebec-for-producing-asbestos.html>
8. The Canadian Press. (2011, August 13). Asbestos In Canada: Balcorp Ltd. Trying To Raise Funds For Jeffrey Mine in Asbestos, Quebec, Seeking Deadline Extension. *The Huffington Post*. Retrieved from http://www.huffingtonpost.ca/2011/08/14/asbestos-quebec-balcorp-jeffrey-mine_n_926262.html.

THE TRUTH ABOUT MEDICAL SAVINGS ACCOUNTS

We frequently hear that the Canadian health care system requires creative new financing models to keep it sustainable. As physicians, it is crucial that we are informed about the pros and cons to various models of financing. One such model mentioned frequently as a "solution" is that of medical savings accounts. Neil Dattani explains why we should be sceptical.

Introduction

Medical savings accounts (MSAs) are one of the many options available to fund healthcare services. They are currently in use in various countries and details vary from country to country, but overall the principle is the same: governments distribute healthcare funding to everyone through individual accounts, and people use the money in their account to pay for healthcare. This

money is enough to cover most minor expenses such as routine visits to the doctor, however it is generally not enough to pay for more complex healthcare services such as operations or care for chronic conditions. For this reason, in most cases MSAs must be supplemented by high-deductible or 'catastrophic' insurance. As the names imply, patients must pay a significant amount themselves before any insurance kicks in, mak-

ing the insurance only useful in medical 'catastrophes'.

Examining two main arguments in support of MSAs

Advocates for MSAs suggest they will decrease the overall demand for healthcare, and reduce healthcare costs. While it is impossible to know for sure how MSAs will impact Canadian healthcare until the exact

(continued on page 13)

THE TRUTH ABOUT MEDICAL SAVINGS ACCOUNTS (continued)

funding details are made public, current research and evidence from the experiences of other countries strongly suggest that MSAs will not yield these benefits in Canada.

It is hard to imagine how MSAs would decrease the true demand of healthcare services. Demand for healthcare is dependent on how often people get sick and to what degree. MSAs would only foreseeably decrease demand in the business sense of the word - that is they would decrease consumption by low income Canadians. Less wealthy Canadians will likely be forced to conserve their MSA funds and avoid expensive healthcare services, in order to limit the amount they pay out of pocket when the funds in their account are depleted.

Furthermore, although many Canadians would have less access to care, overall healthcare costs would not necessarily be lower - in fact, they could very possibly increase. There are many hidden costs associated with the implementation of MSAs, such as administrative costs, which would needlessly raise expenditures. Additionally, the introduction of a parallel, privately funded system would expectedly follow the introduction of MSAs, as explained

later in this article. People who can afford services within this system would likely emphasize reduced wait times and more luxurious (but not necessarily medically better) treatment over cost minimization, further increasing overall healthcare costs.

Another major drawback of MSAs

In addition to the fact that they offer no reliable advantage, MSAs have several disadvantages. Arguably the biggest disadvantage is that they contradict the ideals of Canada's public healthcare systems.

At the core of Canada's publicly funded healthcare systems is the belief that access to healthcare be based on need, not income. However, the consumer-level incentive for spending less in a system funded by MSAs would generate enormous pressure for the widespread legalization of private, for-profit healthcare institutions, to reduce the demand for publicly funded (i.e. MSA-funded) services. While it may seem possible for public and private systems to coexist, evidence from other countries indicates that in such scenarios the public system loses quality over time. This occurs because more resources are pumped into the private system by those who can afford

it. The end result: a two-tier system, in which the wealthy have better access to healthcare.

Moreover, the possibility of MSA-dependent Canadians being discouraged from using the funds in their account to limit out of pocket expenses, along with the high-deductible part of the necessary catastrophic insurance plan Canadians would need to buy, would be in opposition to the main goal of the Canada Health Act: to provide medically necessary physician and hospital services to all Canadians, without any payment out of pocket.

Conclusion

It is a difficult time to make healthcare decisions, as there is a clear discrepancy between what changes are needed and which will offset increasing healthcare costs. However, one decision is simple - remove medical savings accounts from the list of changes being considered. They are clearly not the best way forward, as they neither address the current shortcomings in healthcare, nor do they offer an acceptable way to minimize costs. ♦

PUBLIC-PRIVATE PARTNERSHIPS IN ONTARIO: A DISASTROUS WAY TO DEVELOP HOSPITALS

Jillian Alston

Originally dubbed P3's and more recently branded as Alternative Financing and Procurement (AFP) models are methods for financing health care that have been advertised as delivering health care institutions at a lower cost to taxpayers. They are based

on the assumption that transferring the risk associated with large construction projects to private service providers saves money, allowing the government to more cheaply finance new hospitals. However, if you take a closer look at AFPs, it does not take long to realize that they are not

as attractive as they seem.

What are AFPs?

AFPs are public-private partnerships that use private financing to rebuild infrastructure while retaining public ownership.

(continued on page 14)

PUBLIC-PRIVATE PARTNERSHIPS IN ONTARIO (continued)

The United Kingdom established similar partnerships through their Private Finance Initiatives (PFIs) in the 1970s. A review demonstrated that PFIs had higher costs and were much less efficient as compared to public initiatives. The British Medical Association has warned that PFIs wasted National Health Service money and are not commensurate with public interest. Unfortunately, the Ontario government has not heeded this advice as they have proceeded with AFPs. To make matters worse, they have afforded private investors more freedom than the UK government did.

As predicted, AFPs have not been delivered on their promises in Ontario either. For example, the Brampton Civic Hospital, which upon completion two years past its planned opening date, the hospital included only 479 of the promised 608 beds and at a cost of \$300 million more than planned. Ontario's Auditor General estimated that the government could have saved \$50 million immediately and \$200 million in the long run if the hospital

were built publicly and financed with available borrowing rates.

Myths and Truths About AFPs

Won't AFPs save the government money?

No. Although private investors finance the initiative, the government and ultimately the taxpayer repays the investor over many years. AFPs cost more to the public as they utilize private financing rates versus the much lower rates offered to the government. As well, there are no regulations that prevent AFPs from going over budget. AFPs also generate millions of dollars in costs due to legal and administrative fees and insurance premiums, often comprising 10% of the constructions costs. The private sector is profit driven and in contrast to public hospitals, where any profits are recycled into to patient care.

Are AFPs more timely and efficient?

There is no evidence to suggest construction under the private sector is timelier. Any increase in efficiency benefits the private sector in profits. To generate profits, the private sector must charge more or

cut corners (often they cut corners in non medical services, such as food and housekeeping, which can be linked to increased transmission of infectious disease).

Don't AFPs maintain public interest?

Multiple reviews suggest AFPs cost more and don't deliver the number of beds needed. Why are we settling for less at a greater cost?

What does the future hold for AFPs?

The McGuinty government initiated a plan for 14 hospital AFPs in 2003 and proposed savings of over \$300 million. However, reviews suggest this plan will result in public spending approximately \$500 million in extra costs. Political parties should be encouraged to detail their opinions on AFPs in healthcare during the next provincial government, and be reminded on their responsibility to represent public interest.

For more information email jill.alston@live.com, studentsformedicare@gmail.com or medicalreform@sympatico.ca ♦

HEALTH FOR ALL

Michaela Beder

Health for All is a migrant justice organization that seeks to improve access to healthcare for those who remain uninsured in Canada. The article below outlines the magnitude of this problem and makeup of the population affected as well as the challenges they face.

Even though we are taught in medical school that Canada has a universal healthcare system, in reality there are more than 500,000 people living in this country without medical coverage. This population includes undocumented people without immigration status who work in our fields, homes and industry, rejected refugee claimants fleeing persecution. In addition, it includes new permanent residents who have been in Ontario, BC and Quebec for

less than 3 months.¹ Many others, including temporary foreign workers, face multiple barriers including well-founded fear of deportation should they become ill.²

Unless they are one of the 12,000 who receive care through Community Health Centres, these members of our community routinely suffer the health consequences of lack of access, delayed care, denial of service in the emergency department, and if they are hospitalized

then a devastating bill. In one study, research showed that of the uninsured pregnant women who sought care at a Toronto clinic, 60% had deficiencies in prior antenatal care.³

One of the organizations looking to address the root causes of this unjust situation is Health for All. We are a multidisciplinary group of migrants, healthcare professionals, students, activists and allies. We believe health is a fundamental human

(continued on page 15)

HEALTH FOR ALL (continued)

right and a matter of social justice.

Health for All sees immigration status as a social determinant of health, one that impacts not only a migrant's ability to access healthcare, but also access to the basics of life such as housing, food, childcare, education, and social services. Over the past few years, and particularly un-

der the current Conservative government, we have seen a major decrease in the numbers of refugee claimants accepted⁴, while at the same time a drastic increase in the number of temporary workers, a class of migrants that has few rights and is easily exploited. We expect that these changes will result in more people

remaining in Canada without documentation, further heightening the urgency of addressing this situation and ensuring people have access to healthcare.

Health for All has been instrumental in drawing attention to the medical implications of denying cov-

(continued on page 16)

MRG MEMBERSHIP APPLICATION

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

Membership Fees

- \$245 Supporting Member
Physician
Affiliate (out of province) physician
\$60 Intern / Resident / Retired / Part-time
Organization
Newsletter Subscriber
E-Newsletter Subscriber
Free Medical Student /
Medical Research Student

Please specify membership category:

Please specify areas of interest and expertise:

Name _____
Address _____
City _____
Province _____
Telephone _____
Fax _____
E-mail _____

Please charge my MasterCard/Visa in the amount \$ _____. My credit card account number is:
Name of Card holder:
Expiry Date:

Mailing Address:
Medical Reform Group
Box 40074
Toronto, ON M6B 4K4

You may pay your membership fees and supporting contributions through our monthly payment option by completing the following authorization and **enclosing a blank cheque, marked "VOID" from your appropriate chequing account.**

I authorize my financial institution to make the following electronic payments directly from my account:

The amount of \$ _____ on the _____ day of each month, beginning _____, 20_____.

Please credit the payments to the ALTERNA Savings and Credit Union account (No. 1148590) of the Medical Reform Group. I understand that these electronic payments will continue until I give notice in writing to the Payee to stop doing so; that I must notify the Payee in writing of any changes to the information in the authorization; and that I must notify the Payee within 90 days of any error in the electronic payment.

Account holder's name (Please Print)

Account holder's signature

Date

HEALTH FOR ALL (continued)

erage to people living and working in Canada. The group highlights the root causes of this denial, namely an unjust and exploitative immigration system, along with Canadian government policies that are complicit in causing global migration, such as war and neoliberal economic policies.

Health for All has presented at conferences and in medical school lectures, participated in No-One Is Illegal's⁵ annual May Day marches demanding Status for All, and organized several panel discussions on topics such as "Fixing a Broken Healthcare System for Immigrants and Refugees," and "Cutting Deeper: the Age of Austerity and Implications for Health.. We have also been vocal in critiquing Bill C-49 (renamed Bill C-4), which seeks to criminalize any migrant who arrives as a result of a "smuggling incident,"

and which, if passed, would deny these refugee claimants the right to dental care, vision products, and assistive devices, as well as incarcerating both adults and children for up to a year. Health for All also works in solidarity with individuals facing grave health challenges due to their precarious status. There is a desperate need for access to health services.

Health for All calls for access to health services without fear of debt, denial of service, detention, or deportation. We call for universal health coverage for all people in Canada, and for universal regularization (immediate immigration status) for all people in Canada, solely on the basis of their being human.

Please get in touch with us if you have any questions at healthforalltoronto@gmail.com or check out our website at health4all.ca ♦

References

1. Reviewing the OHIP Three-Month Wait: an unreasonable barrier to accessing care. OMA Policy Paper. Ontario Medical Review. April 2011, p13
2. Preibisch, K and Henneby, J. Temporary Migration, Chronic Effects: the health of international migrant workers in Canada. CMAJ. April 18, 2011.
3. Caulford, P & Vali, Y. Providing healthcare to medically uninsured immigrants and refugees. CMAJ April 25, 2006 vol. 174 no. 9
4. Dench, J. Canadian immigration, changing priorities. Canadian Council for Refugees. April 2011. Retrieved Aug 21, 2011. <http://ccrweb.ca/en/canadian-immigration-changing-priorities>
5. No-One Is Illegal: toronto.noone-isillegal.org

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]*