Medical Reform

Newsletter of the Medical Reform Group

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A NEW RELATIONSHIP FOR THE OMA AND ONTARIO GOVERNMENT? FALL MEMBERS MEETING REPORT

Janet Maher

In the midst of the dispute between the Ontario Ministry of Health and Long Term Care and the Ontario Medical Association, the Medical Reform Group, along with Students for Medicare, hosted an educational session on the OMA-Ministry negotiations, moderated by Toronto family physician Ritika Goel. The session was attended by about 50, half members and half visitors and sought to present an alternative perspective to what had been largely covered in the media.

The speakers, Dr. Ahmed Bayoumi and Steven Barrett both brought their expertise on the history of OMA-Ministry negotiations and pay, one coming from the physician perspective and the other from the legal aspect. Bayoumi is an internal medicine specialist and health services researcher at the Centre for Research at Inner City Health at St. Michael's Hospital in Toronto and started off with a presentation on the economic background of the dispute. Steven Barrett is a managing partner at Sack Goldblatt Mitchell and practices in the areas of labour law, Charter of Rights and constitutional litigation and public interest litigation and followed by a historical and political analysis.

Context for the 2012 negotiations

Bayoumi began by setting the background of the 2008 recession and the government's 'austerity' agenda made explicit in the realm of healthcare where they announced no more than a 2.1% annual increase. Thomas Walkom wrote in the Toronto Star that the government chose physicians to start with to make an example out of them. Why? Because they are well paid, privileged, and they likely felt this would make it easier to subsequently negotiate with other groups such as teachers.

Physician pay is rising

Bayoumi summarized the information from data from earlier this year on physician incomes, adjusted for inflation from the 1992-93 base year. In 1993, physician gross incomes were just below $200,000 and in 2009-10, they were just over

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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

The tug of war between the Ontario Medical Association and the Ontario government came to an end, at least temporarily on December 9th, 2012 with the OMA's ratification of a two year deal which will take a 0.5% discount from all members, and work to achieve an additional 1% 'savings' over the life of the agreement with targeted measures on procedures with limited or no evidence of value. As noted in our brief review of the agreement, the genie has been pushed back in the bottle at least for the time being.

Some specialists, as noted, were very reluctant parties to the agreement, and there are some signs that they will continue to look for ways to maintain their recent income levels—most likely by re-opening the extra-billing bogey with additional services not covered by OHIP, if early reports of cataract patients are to be believed. We will be continuing to monitor this—if you have information, please let us know.

The fourth anniversary of the Ontario Poverty Reduction Strategy has come and gone, and despite the best of intentions of all parties in 2008 when the strategy was announced, it seems unlikely that the government will meet its very modest objective of reducing the number of Ontario children in poverty by 25 per cent. Indeed, after a peak in 2010, poverty rates are expected this year to exceed those of 2007, the year before the strategy was implemented. To add insult to injury, since the release of the report of the 2 person Social Assistance Commission, we have seen a succession of announcements to eliminate many of the most critical special or one time allowances to which some recipients had access, and which could mean the difference in whether an individual or family kept its precarious housing or a child had warm clothes for school.

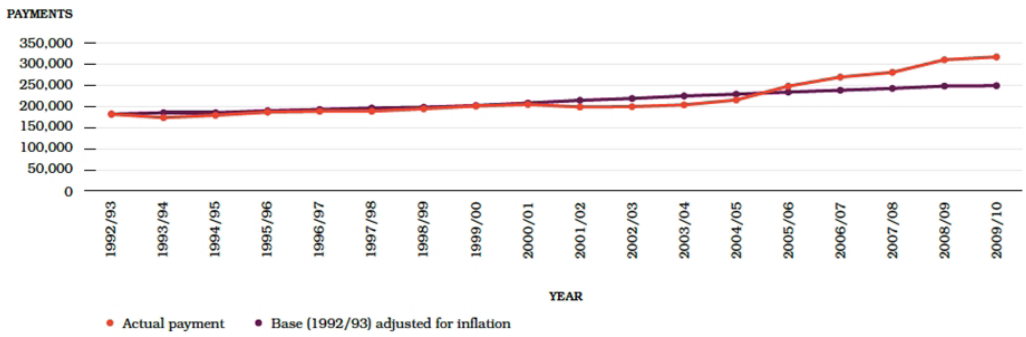
In mid-October, Premier McGuinty resigned, giving rise to a leadership convention which will happen in Toronto on January 25th-27th, 2013. Given the minority position of the government, it seems likely that there will be a provincial election this year, with some good options for advocates to press their case for fairness—to people living in poverty, to new immigrants and refugees, and to First Nations as well as the public in general.

Best wishes for good health in 2013.♦

A NEW RELATIONSHIP (continued)

$280,000. The purple line represents what would have happened if physician income had kept pace with inflation therefore demonstrating that until 2004-2005, incomes rose mostly with the rate of inflation, but since then they have increased much faster. By 2010, the average physician income was approximately 20% higher than the rate of inflation.

FIGURE 1 Mean annual payments per head to all Ontario physicians and inflation-adjusted base (1992/93) payment, 1992/93 to 2009/10



Between 2005/06 and 2009/10, the median payment per physician increased by 25%, from approximately $227,000 to $283,000.

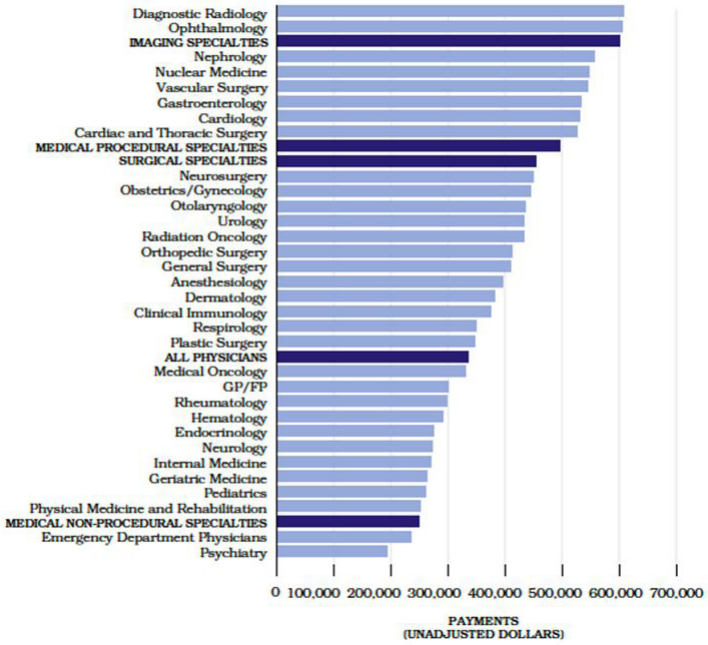
Fee Schedule Not Uptodate with Technological Efficiencies

Not all physicians have had the same income experience. Some specialties are considerably better paid than others. Radiologists and ophthalmologists have an average pay in the $600,000 range. In 1992-1993, ophthalmologists were a little bit above average, but in recent years their income has shot up. This is largely thought to be due to reimbursement for cataract surgery which has become much faster as a result of technological efficiencies meaning an effective increase in hourly pay.

Some Insured Services Have Low Value

Bayoumi discussed the June 2012 issue of US Consumer Reports. This magazine declines advertising and does testing and rating of a broad range of consumer items. Last year, in a partnership with the American Board of Internal Medicine, the magazine asked medical subspecialty agencies to identify five medical tests that are of no or low value in their specialty. The goal was for medical associations to work with physicians and other providers to stop ordering the tests, and consumer organizations to work with patients to stop asking for the tests.

FIGURE 2 Average payment per physician from all sources by specialty and specialty group, in Ontario, 2009/10



Bayoumi explained that a lot of what physicians do is actually of little value. In the United States, it is estimated about 30% of physician activities are of no or little value to patient outcomes. In effect, these are the extra tests that are done to reassure people or to ward off medical liability. Unfortunately, sometimes the tests can actually be harmful. This would be a good place to start when considering cutting costs.

The OMA is not our Union.. Yet!

Bayoumi reminded the audience that the OMA is not a union for Ontario doctors, but a professional association. While all physicians in Ontario have to pay the OMA fees, they do not have to join the OMA but most do. Since 1991, however, the OMA has been acting as an official negotiating agent for physicians. How much is paid for a given service is to some extent historical since the

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fee schedule has been in place for a long time. For the past 20 years or so, agreements are generally negotiated for three or four years with little change in the structure of the fee schedule. It is worth noting that the finalized negotiations have more effectively made the OMA the official physician union.

The Tug of War between the OMA and the Government

In February 2012, the OMA and the Ministry of Health and Long Term Care started negotiating the new services agreement but a few weeks in the OMA issued a press release saying they had reached an impasse. In March, the OMA asked the government to negotiate with the assistance of a third party conciliator saying direct negotiations were not fruitful. It is worth noting that negotiations are typically conducted behind closed doors, so we only know what one side or the other has chosen to reveal.

The Initial OMA and Ministry positions

The OMA said they proposed a freeze to the fee schedule for the next two years as they knew asking well-paid physicians to be paid more when other public sector workers were being asked to take freezes or cuts would not be palatable. The OMA committed to saving $250 million in the course of next two years without providing details on how this would happen but an implication that the focus would be on low or no value services. The OMA states the Ministry proposal which would freeze the amount allocated to medical services at the 2011 level would be an effective decrease in individual physician incomes as the number of physicians would continue to rise meaning each physician would be paid less.

In the past, the Ministry used income thresholds to manage costs so if a physician billed more than a certain amount, she would get paid, say, seventy-five percent of the fee schedule, and then if she exceeded another certain threshold, she would get paid only fifty-percent of the threshold and so on. This often targeted diagnostic services. Part of the agreement also partially reimburses malpractice insurance premiums for some physicians, and there was discussion of shifting this to most physicians.

Bayoumi summarized estimates of the impact of the government proposals from the OMA website which suggests there would be about a 3.5% per cent decrease in physician income for the next fiscal year if the government position were accepted. The OMA estimated six specialties would get a reduction of 5-10% while cardiology and ophthalmology would see declines in the 10-15% range. When the OMA projected these proposals to 2015-2016, they arrived at a cut of about 11.7% over 4 years, compared to the government's stated goal of 2.1% a year.

Ministry-proposed fee changes

Some of the services for which the Ministry proposed fee changes include:

- For reading electrocardiograms – the fee would decrease by 50% as many cardiologists read many ECGs quite quickly and get paid a lot for it. As well, most places now have ECGs that provide a computer diagnosis. This change was estimated to save $21 million.
- Interpreting results for diagnostic radiology were proposed to decrease by 5% and save an additional $30 million.
- Self referral – If a physician would refer to herself for diagnostic tests, for example, a cardiologist who owns an echo machine she would get paid only 50% of the fee for that service for an estimated annual savings of about $44 million. This was quite contentious as many physicians work in group practices so would count as a self-referral often when the same facility is doing a diagnostic test but the physician has no financial stake in it. Bayoumi noted that this was the least well thought out part of the government's proposal.

Media Fanfare

In the fall of 2010, the government refused to sit down initially at the negotiating table until the OMA agreed on the principle of a cap ie a freeze on global payments. The OMA then distributed a petition that they wanted members to post in waiting rooms, offices and patient areas. The Medical Reform Group expressed concern to the College of Physicians and Surgeons of Ontario about the nature of this petition (See news release this issue).

Bayoumi noted that in the view of the MRG, the government should not be paying for services where evidence suggests they're unlikely to improve health and noted this has been more carefully studied in the US. This can be difficult as patient preference can often be a strong motivating factor.

Bayoumi explained that fees should reflect efficiency so the cost of a procedure might be expected to decline over time as prices are adjusted. Physician incomes are at a

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A NEW RELATIONSHIP (continued)

historical high in this province, and they've increased well beyond the rate of inflation. At the same time the ministry approach of unilateralism had not been at all helpful in getting to a resolution of the dispute.

Stephen Barrett Presentation: a Short History Lesson

Barrett reviewed the history of OMA-Ministry negotiations including the shifting nature of the relationship in seven relatively distinct periods.

1. Mid-1960s: The Beginning of Medicare
   Ontario's first introduction of public insurance for medically necessary physician services. Before this time, doctors got paid through private insurance, direct payment by patients, and some charity. Before this time, the OMA prepared a fee schedule which outlined recommended fees for various procedures, and had been doing so since approximately 1922. From the mid-1960s to the mid-1980s, doctors could bill what they wanted. Most followed the OMA recommended fee schedule though the bulk of their income came from government insurance. Private insurance was banned and although a few doctors billed directly, even they billed what the government paid on the OMA fee schedule.

2. 1973-1984: OMA Decides Fees to the Establishment of the OHIP Fee Schedule
   In 1973, the government and the OMA formed the Joint Committee on Physician Compensation, that issued reports from 1973 through to 1977 for the OMA schedule. In 1977, the OMA asked for a 36% increase as they stated they had fallen behind in inflation by 40%.In response, the government established what we know as the OHIP fee schedule. In this time, the total amount increase was negotiated but the OMA sections decided what portion would go to family doctors vs. specialists. In 1981, a fact finder (a process for settling issues on which the parties could not agree) was set up. In 1982, the government did not accept the result of the fact finder. In 1984, with the general public wage control limits, the treasurer of Ontario overrode the agreement the OMA and the government had reached and set the increase unilaterally at 5%, rather than the 7% that had been agreed to by the Joint Committee on Physician Compensation.

3. 1984: Canada Health Act
   The Canada Health Act penalized provinces that allowed extra billing which an increasing number were engaged in. This was banned in Ontario through the Health Care Accessibility Act which also set the OMA as a bargaining agent for physicians in negotiating the fee schedule. In 1988, the government and the OMA disagreed over the fee increase, the government imposed a lower increase on the OMA and terminated the Joint Committee agreement.

4. 1990-1995: Provincial NDP Government
   An attempt was made to turn the OMA into a union which resulted in the OMA Dues Act in 1991 requiring all physicians to pay dues to the OMA. The OMA still retained unilateral authority to decide on how to allocate fee increases among the specialties. In 1994, with the Social Contract, there was more control legislation, this time from the NDP government. That's when the utilization controls and thresholds were introduced.

5. 1995-2000: Early Harris Years
   Harris did not like the arbitration with the OMA and legislatively extinguished the OMA's right to arbitration and all the other agreements. During this time, a 6.5% cut was made in 1996 and 3.5% cut in 1997. The OMA also became very fragmented as the government started to negotiate with separate specialty groups some of whom threatened to withdraw services so the government realized they needed the OMA for negotiation.

6. 2001-2012: Four Year Agreements Begin
   Arbitration ended and we saw the first of several four year agreements with fairly modest increases of around 1.5% a year over four to five years. A Physicians Services Committee was created which was to be cooperative and evidence-based for the OMA and government to look to for efficiencies. There was however an explicit acknowledgement that the OMA controlled the fee schedule, as well as the allocation of different services and specialties and any changes to the amounts paid.
   In 2001, the OMA began to wrestle with the government and get significantly higher increases. The same thing happened in 2004-

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2008 with targeted increases in some specialties. In 2007, the Liberals created the Medical Services Payment Committee which was intended to look at the issue of allocation of fees to various specialties. The last agreement in this period was the 2008-12 agreement, entered into as the economy was collapsing giving physicians approximately a 12% increase over four years and other additional amounts invested for physician funding. This was consistent with settlements for other public sector employees, including teachers.

7. Age of Austerity
   Things have changed again in the seventh period, when the government had already signaled its intent to impose compensation decreases unilaterally on teachers, and expected to do something similar with doctors. Barrett referred to an essay he wrote for healthydebate.ca when the OMA proposed a constitutional challenge over the government's decision to act unilaterally.

It is worth noting that the OMA's response was not to withdraw services. Barrett noted that when that was tried in the past, it didn't work out very well for them. It was also felt the public would not support a strike and some physicians did not see a strike as consistent with their professional obligations.

Other health care workers who are not allowed to strike generally have the right to independent interest arbitration as the OMA did in the early 1990s. Although it seems sensible public policy to amend (i.e. reduce) fees when technology or other practices reduce the work performed by the physician, it is not necessarily clear how best to go about this. The government's unilateral approach may have been unhelpful in maintaining the cooperation of doctors whose input would be needed to achieve change on a broader level.

The government also lost support on the issue of providing medically necessary services considered self-referrals which left doubt about when the fee would be payable. The Canada Health Act does not require arbitration or third party intervention but the accessibility condition means paying physicians a reasonable compensation.

In the week before the members meeting, the OMA and government had returned to the bargaining table. The government would want a deal before the next election and the OMA needed one for its legitimacy and credibility as a professional organization. The OMA continues to have its constitutional challenge outstanding, but it is not clear if they will want to continue with it.

Barrett suggested that negotiations with physicians aren't really like negotiations with other employees. We are not just talking about a salary or hourly wage negotiation because physicians have such a significant part in broader public policy, and the government needs physicians and physician institutions to reform the system. At the end of it all, Barrett felt this would need to be reflected in a way of going forward that will give both sides incentives to come to an agreement.

Final thoughts

The presentations gave rise to a lively question and answer period. Bayoumi concluded his response to questions by noting the complexity of the issues and a social code amongst physicians in which the ethic of caring generally overrides the desire to make money. While he acknowledged that monetary incentives do influence behaviour, he remains convinced that the primary motivation is still a desire to help their patients.

Barrett spoke briefly to the legal challenge filed by the OMA on the freedom of association provisions to allow collective bargaining, noting that this appears to have been a strategy to get recognition of the inappropriateness of the unilateral government approach. He also underlined the realities faced by both the OMA and the government—the OMA needs at all costs to maintain unity in the profession, and the government needs to be in control of policy and budgets. It is very hard without some form of external pressure for the OMA both to represent all specialties and individual specialties within the profession and to make changes. It has historically had a very hard time policing and enforcing change internally. For the most part, the OMA has controlled the fee schedule and this is an extreme reaction by the government for the years the OMA has been unwilling and unable to make changes.♦

OMA AND GOVERNMENT REACH TENTATIVE AGREEMENT ON FEE SCHEDULE FOR 2012-14

Janet Maher with files

On December 9th, 2012, OMA members ratified a new 2 year agreement with the province. Key components of the agreement include an across the board discount of all billings by 0.5 per cent and commitments to work together on a package of savings and investments intended to keep the increase in expenditures on physician payments within the government's 2 per cent ceiling.

Economic Package Highlights

Beyond the across-the-board discount, the details of most of the investments and other changes will be the subject of additional committee deliberations. Although the expectation is that $100 million will be saved with these changes, neither the government nor the OMA have so far provided a plan for how this might happen.

- After hours care:
  - Primary care groups will have added responsibilities to provide after hours service, but with little monitoring or focus on acknowledged bottlenecks on weekend care
  - premiums proposed for reduction in the April 2012 agreement have been restored to the 2011 level of 50 per cent for evening and 75 per cent for after midnight
  - some improvements for physicians providing house calls, but formula for determining patient criteria to be developed by a primary care working group during the life of the current agreement
- Diagnostic tests:
  - Some specific tests where there is agreement of limited or no clinical benefit have been dropped from the schedule
  - The frequency for reimbursing other tests will be reduced for low-risk patient groups
- E-health and virtual care
  - Evaluate current pilot projects and make recommendations for integrating more excellent practice into existing business models
- Interdisciplinary care
  - Up to $40 million (approximately 1 per cent of total primary care billings) to be invested in expansion of non-physician services (pharmacy, dietetics and the like) from CHCs and Family Health Teams to other practice models

In preparation for the vote, the Ontario Medical Association prepared an estimate of impacts by specialty. For most specialties, the estimated impact (reduction) is under 5 per cent, but for 4 specialties—cardiology, ophthalmology, vascular surgery and neurosurgery—the effect of the new agreement ranges from 11 per cent to 20 per cent. An examination of the results of the vote indicate the same specialties opposed the settlement in much larger numbers.

The relationship between government and the OMA

On November 26th, Steven Barrett offered an assessment of the new agreement for readers of the Healthy Debate Blog as an update to his earlier article on the constitutional challenge filed by the OMA earlier in 2012.

In the update, Barrett focuses on the effect of a new separate agreement on OMA Representation Rights and Joint Negotiation and Dispute Resolution which will serve in effect as a framework for future interaction. This new agreement confirms the right of the OMA as exclusive representative of all Ontario physicians except for residents and those directly employed by the government itself in both compensation and consultation on broader health policy issues. It also outlines a process for future negotiations over all practice arrangements which should obviate the unilateralism that marred the 2012 talks. In return, the OMA has agreed to withdraw its constitutional challenge. It remains to be seen how well the process has served the OMA in maintaining unity among its members and the government in meeting its objectives to slow the growth in health expenditures in a recessionary period.♦

For more information, see healthydebate.ca or the Ontario Medical Association website.

Ontario Health Coalition
Health Care Cuts Backgrounder & Quick Facts

December 2012

The "austerity" budget plan of the McGuinty government aims to carve >$3 billion from health care funding.

Ontario is in the first of a five-year "austerity" budget plan. ("Austerity" refers to a particularly harsh approach to budget cuts, public service cuts and privatization, and labour force restructuring.) Global budgets for hospitals are set at 0% - in real dollar terms this is a significant cut -- far less than enough to meet inflation, let alone population growth and aging. Seven months into the fiscal year, home care funding is just being released. Twelve of 14 Community Care Access Centres have allocated their home and community care funding. Home care funding is insufficient to meet the current waitlists and offloading of hospital patients.

As a result, hospitals and Community Care Access Centres across Ontario are cutting services, waitlisting patients/clients, and posting deficits.

The Ontario Health Coalition has released its first edition of a new collection of cuts, privatization and deficits. Called the "Austerity Index" it can be found at www.ontariohealthcoalition.ca . Regular updates will be released as information about cuts is collected by the coalition.

Latest national health statistics show Ontario ranks 8th of 10 provinces in health care funding

Rising health spending is the primary argument used to justify cuts. Contrary to false claims by Ontario's Health Minister of wildly increasing health spending, in fact Ontario ranks 8th out of 10 provinces in health care funding – both on a per capita basis and as a percentage of provincial GDP. See Tables 1 & 2. Health care funding in Ontario is shrinking, not growing, as a proportion of the provincial budget. Hospital funding in Ontario is the lowest per capita of any province in the country. (Source for health and hospital spending data: CIHI 2012 National Health Expenditures Database.)

Table 1.

Ontario Public Health Care Spending Per Person 2012 Compared to Other Provinces (Current $)	
Newfoundland	$ 5,399
Saskatchewan	$ 4,952
Alberta	$ 4,896
Manitoba	$ 4,816
PEI	$ 4,663
Nova Scotia	$ 4,463
New Brunswick	$ 4,377
Ontario	**$ 3,963**
British Columbia	$ 3,937
Quebec	$ 3,792
Average Other Provinces	$ 4,588
Difference Between Ontario and Average of Other Provinces	**- $ 635 per person x 13,529,000 people = $8.6 billion less**

Table 2.

Ontario Public Health Care Spending As a Percentage of Provincial GDP Compared to Other Provinces 2012	
PEI	12.79 %
Nova Scotia	10.97 %
New Brunswick	10.63 %
Manitoba	10.14 %
Newfoundland	8.97 %
Quebec	8.77 %
British Columbia	8.16 %
Ontario	**8.07 %**
Saskatchewan	7.30 %
Alberta	6.21 %

Source: all per capita spending data is from the Canadian Institute for Health Information (CIHI), National Health Expenditures Database, 2012. Percentages of GDP calculated using CIHI GDP figures from the National Health Expenditures Database, 2012.

Health care spending shrinking not growing/ Ontario ranks last in Canada in all program funding

Contrary to the claims of this government, a review of Ministry of Finance Ontario Budgets for the last decade shows that health spending in Ontario is *shrinking*, not growing, as a percentage of the provincial budget. See Chart 1. To put Ontario's health care funding picture into context: Ontario's health spending is a declining share of all provincial government spending on all programs, and Ontario's spending on all programs and services ranks last of all provinces in Canada. (See Ontario Ministry of Finance, 2012 Budget Chart 1.10 here: http://www.fin.gov.on.ca/en/budget/ontariobudgets/2012/ch1.html#c1_chart10)

- Hospital funding is shrinking as a proportion of health care spending and is now the lowest per person in Canada. See Table 3.
- Despite rhetoric aimed at covering up service cuts, Ontario's home care funding is shrinking as a proportion of health spending (data for pan-Canadian comparisons not available).

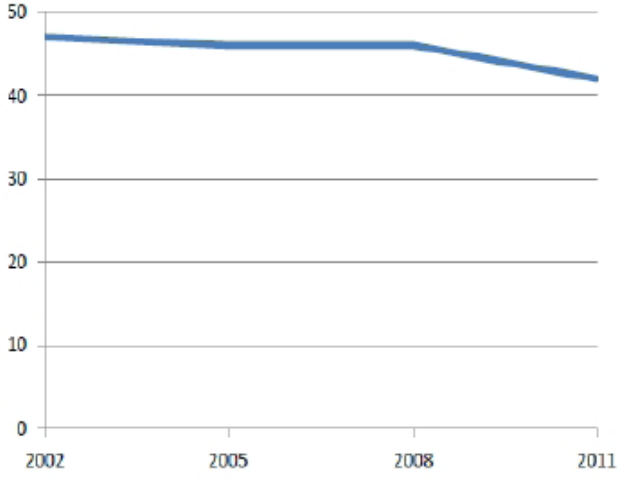
$15 billion in fiscal capacity annually, lost through erosion of the tax base

Why are we facing such a funding crunch? In a dubious first, Ontario led the country in tax cuts – both corporate and personal income tax cuts primarily benefiting the wealthiest and corporations – starting in 1995 under the Mike Harris government, but continuing also through the McGuinty government with ever expanding corporate tax cuts. Ontario ranks now among the very lowest corporate tax jurisdictions in North America, and continues to plan corporate tax cuts despite the failure of corporations to invest in Ontario. This erosion of the tax base was compounded by the 2008 recession, leading to the deficit. The impact of the tax cuts for the wealthy and corporations should not be understated. Economist Hugh Mackenzie calculates that Ontario is now losing $15 billion each year in forgone tax revenue that could have been used to provide public services like health care that benefit everyone.

Table 3.

Ontario Public Hospital Spending Per Person 2012 Compared to Other Provinces (Current $)	
Newfoundland	$ 2,519
Alberta	$ 2,194
New Brunswick	$ 1,962
Manitoba	$ 1,843
PEI	$ 1,831
Saskatchewan	$ 1,784
Nova Scotia	$ 1,762
British Columbia	$ 1,557
Quebec	$ 1,381
Ontario	**$ 1,372**
Average Other Provinces	$ 1,870
Difference Between Ontario and Average of Other Provinces	**- $ 498 per person x 13,529,000 people = $6.7 billion less**

Chart 1. Health care funding as a percentage of all Ontario program spending



Source: Ontario Ministry of Finance, Ontario Budgets 2002, 2005, 2008, 2011.

FILL THE IFH GAP: A CALL TO ACTION IN THE LIBERAL LEADERSHIP CAMPAIGN

Health For All

In response to drastic cuts to the Interim Federal Health (IFH) program in Canada, 2012 was marked by historic mobilizations where health care workers and allies took to the streets, occupied Conservative MP offices, rallied outside Citizenship and Immigration Offices, launched a Non-Cooperation Campaign in response to drastic cuts to refugee health care coverage in Canada. These cuts mean a man in Saskatchewan was denied chemotherapy for his cancer treatment, pregnant women have been denied coverage for their deliveries, countless refugees and claimants have been cut off from access to medications and now, those seeking refuge from countries Jason Kenney has designated as 'safe' will not be able to get care even for a heart attack. These cuts are in line with ongoing regressive immigration policies introduced by this government including Bill C-31.

In the wake of these cuts, Quebec has stepped up to fill the gap by providing health care coverage for refugees. Manitoba has said they will do the same and send the Feds the bill. Saskatchewan has called for a review of the cuts and provided chemotherapy for a dying man. Yet, we have seen no action from Ontario and it's time we escalate our demands. As a New Year's resolution, we are asking you to JOIN US in calling on the province to step up, FILL THE IFH GAP, and provide healthcare coverage for all those seeking refuge in Ontario. Help us make this an issue in the Ontario Liberal Leadership race by participating in our three upcoming Wednesdays of Action leading up to the Leadership Convention!

1. The next three Wednesdays in January (Jan 9th, 16th, 23rd) leading to the convention, we need your help to: flood the communication lines asking Ontario Liberal Leadership candidates to make public statements agreeing to fill the IFH gap if they are chosen.
   A. Phone the candidates.
   B. Email the candidates individually or click here for an easy online form that will email all candidates for you.
   C. Tweet the candidates. Use the hashtag #FillTheIFHGap as well as using the #olpldr and #onpoli hashtags. Scroll down for automatic tweet links.
   D. Have your organization write a letter to the candidates.
2. On Wednesday, January 23rd, at 11.30 am, JOIN US in a public rally to deliver a petition with over 627 signatures of health professionals, social service providers and community members to the Ministry of Health, 900 Bay Street, Toronto. See the petition here: http://health4all.ca/PetitionToMinisterMatthews
3. On the weekend of the convention, January 26th and 27th, help us TAKE OVER the #olpldr and #onpoli hashtags demanding that the candidates promise to #FillTheIFHGap.♦

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Please forward this widely to your contacts, and share the link for the callout here: http://health4all.ca/FillTheIFHGap and the facebook event here: https://www.facebook.com/events/455851527807727/?notif_t=plan_user_joined. For further information, please contact healthforalltoronto@gmail.com! @HealthForAllTO www.health4all.ca

PROGRESSIVE DOCTORS SUPPORT DEAL BETWEEN THE MINISTRY OF HEALTH AND LONG TERM CARE AND THE ONTARIO MEDICAL ASSOCIATION

The Medical Reform Group, a group of doctors committed to universal high quality health care for all Canadians, is encouraged by the tentative agreement between the OMA and Ministry of Health and Long Term Care. The MRG encourages all Ontario physicians to say "Yes" to the deal.

"There are a number of positive aspects to the settlement," said MRG spokesperson Dr. Gordon Guyatt. "First, the OMA's agreement to a roll-back in fees acknowledges that, as public servants, doctors have to consider the government's financial position. We hope that it also acknowledges that physician incomes are so much greater than any other group with which the government is negotiating, and that disparity needs to be taken into account in any settlement."

Dr. Ahmed Bayoumi, another MRG spokesperson, highlighted other positive aspects of the agreement. "The agreement stipulates higher fee reductions for specialties with higher incomes," Dr. Bayoumi noted. "The agreement also takes into account technical advances that make procedures much simpler, and quicker to carry out. This is particularly the case in ophthalmology and cardiology."

There are other major positive aspect of the deal that Dr. Guyatt points out. "The agreement explicitly considers evidence that supports - or doesn't support - specific interventions. For example, the fees now recognize the limited utility of certain aspects of the traditional screening physical examination. The agreement also acknowledges how the face of practice is changing, with the provision for remuneration for email advice to patients."

With all its positive aspects, the agreement is far from perfect. "The gradients between the highest income specialists and other doctors is still too large", Dr. Bayoumi noted. "We would also question the income gradient between doctors and other health care workers. A fully evidence-based fee schedule is still a long way off. All in all, though, the agreement represents a step forward. We strongly recommend a yes vote from all Ontario doctors."♦

MRG News release December 3, 2012

THE ONTARIO POVERTY REDUCTION STRATEGY: MODEST TARGETS—MODEST RESULTS

Janet Maher

The Strategy and Targets

To its credit and in spite of the 2008 recession, the Ontario government acted on its promise to deliver a poverty reduction, and December 4th this year marked four years of the province's five year Poverty Reduction Strategy. The strategy, to cut child poverty by 25 per cent, primarily through a phased-in Ontario Child Benefit scheduled to rise to $1,310 annually by July 2013, and increases in the minimum wage that would reach $11.75 an hour by 2013. Those two measures, along with increases in social assistance benefits that were expected to match any increase in the cost of living, were the basis of a commitment to lift 90,000 of the then-estimated 350,000 poor children out of poverty. Other commitments were to study social assistance and make recommendations that could improve the transitions between welfare and employment for those able to work.

The Results

In 2009 and 2010, child poverty fell by 6.6 per cent, more or less as anticipated. However, since then progress has stalled. The promised increases in the Ontario Child Benefit stopped at 2011, at a maximum of $1,100 per child. The incremental increases in the minimum wage stopped at $10.25 an hour on January 1, 2011. Social assistance rates have increased at approximately a half of the increase in the cost of living. Additional investments have been made in the implementation of full-day kindergarten and child health and development.

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THE ONTARIO POVERTY REDUCTION STRATEGY (continued)

The Social Assistance Reform Commission has consulted and released its results in October 2012. Its main recommendations included:

- Increase the base social assistance rate for single adults on Ontario Works by $100.
- Rule changes to increase asset limits, and the amount of child support and part-time employment income recipients can receive;
- Improving employment supports, enforcing employment standards and improving access to early learning and child care.

So far the government has been silent on the recommendations beyond announcing a one per cent increase in the base rate for social assistance recipients from November 2012 on. However, they have proceeded with plans to streamline various social assistance benefits which have allowed some families some additional supports. At the top of their list has been the Special Diet Allowance which at its height provided up to $250 a month to recipients with special diet needs. In the 2012 budget, the government announced that as of January 1, 2013, it would terminate the Community Startup and Maintenance Benefit—an allowance which provided supports for recipients who have to move house. The budget provided for half of the funding which had been allocated to this benefit to be transferred to municipalities to set up their own programs by 2014; the other half was claimed as savings. Following a community mobilization on this cut, the Government announced at midday on December 27th, that about two-thirds or around $42 million of the cut would be restored and sent to municipalities under the new system.

In the heyday of the Ontario Poverty Reduction Strategy, all three parties in the provincial legislature signed on to its modest goals. Following the resignation of Premier Dalton McGuinty and plans for a Liberal leadership convention, it is likely there will be a provincial election by late spring of 2013—an opportunity for advocates to remind all parties of their commitments.♦

BUTCHERING REFUGEE HEALTH CARE IS LOSE-LOSE FOR CANADA

Ritika Goel

It's a sad day for refugees looking to Canada for protection. Today, Jason Kenney and the Conservative government announced a controversial list of countries that will determine who does and does not get access to healthcare in this country. This 'Designated Countries of Origin' or so-called 'safe countries' list singles out refugee claimants from certain countries fast-tracking their claims and denying almost all coverage for health care services, even in the case of a child with an emergency.

On June 30, the first phase of changes were implemented to the Interim Federal Health Program which provides refugees with health care coverage in Canada. These changes have led to the denial of essential medicines, including psychiatric medicines for a teenager with a history of suicide attempts.

They have removed the temporary coverage given when a claim is first made, leaving a man with a cough suspicious for TB ineligible to access a chest X-ray to diagnose this life-threatening illness. Due to multiple changing versions of the cuts and poor communication, even wider negative impacts have occurred, as in the case of a woman who was 36-weeks pregnant and was asked by her obstetrician to bring $3,000 to her next visit despite having valid coverage.

Today, the most cruel piece of this policy came into play effectively setting up a two-tier refugee system. From this date on, those making a claim from a so-called 'safe country' will have an impossibly short amount of time to prepare for their hearing, will not get access to the newly created Refugee Appeals Division, will have to wait much longer to consider a humanitarian claim, and to top it all off, will have practically no coverage for health care services.

This is what the government has facetiously called "public health and safety coverage" illuminating their limited understanding of the field of public health. These individuals are not covered for preventative care as is needed for children and pregnant women, or even emergency care in the event of a heart attack or car accident. As a family doctor working with refugees and refugee claimants, the potential impacts of this policy are horrifying. We will no doubt see individuals left with

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no choice but to allow their health to worsen before seeking services. This will lead to completely preventable health consequences as well as many avoidable ER visits for conditions that could have been dealt with through prevention and early treatment.

This will no doubt mean extra costs to the system, and despite the name of the coverage, will also jeopardize public health as individuals are unlikely to have memorized the small list of infectious diseases for which they are covered. So it seems to me that this is a lose-lose situation.

Having heard countless stories of individuals who fled countries which we are now deeming "safe," I find this entire concept difficult to accept. The Immigration and Refugee Board, while tremendously flawed, is intended to deal with the individual nature of a refugee claim. When a woman flees domestic violence in Mexico, her claim must be assessed based on this individual situation alone. Countries are included in this list either for having large numbers of claims rejected, withdrawn or abandoned or based on the Minister's opinion that they have an independent judiciary and democratic rights.

Nowhere does this include the country's record on persecution of ethnic minorities, their views on LGBTQ rights or gender equality — all very common reasons for refugee claims. History has taught us that what is safe for the majority and the privileged is not always safe for the minority and the marginalized.

The most outrageous case of this is Hungary, recently the largest source of refugee claimants to Canada. Those fleeing Hungary are largely Roma people known to be ethnically persecuted in this country, with public anti-Roma sentiment expressed by members of political parties, and a recent rash of ethnically-motivated murders. Declaring Hungary a "safe country" makes a mockery of the refugee process.

But protecting individual refugees or the health of the public has never been Minister Kenney's goal. The Citizenship and Immigration Minister has spoken quite loudly with both his actions and words. He has used misleading terms such as "bogus claimants" and "queue-jumpers" to divide migrants and "Canadians" while simultaneously passing increasingly harsher policies punishing migrants.

Bill C-31, which creates the two-tier system between those from "safe countries" and those not, also makes the refugee system much more difficult for all refugee claimants. While in the past, refugee claimants had months (sometimes years) to prepare for a hearing, the new process gives a maximum of 60 days (with those from safe countries getting only 30-45) until their hearing. Many refugee lawyers have called these timelines impossible to acquire the documentation needed to make a proper claim. This will set many refugee claimants up to fail without ample opportunity to demonstrate their persecution.

This same bill also creates a category of Designated Foreign Nationals. These are individuals who the Public Safety Minister deems "irregular arrivals" who are then detained (with infrequent review) and denied access to permanent residency, family sponsorship, and mobility for five years.

While the government claims this policy is in place to crack down on human smuggling, it punishes the very individuals desperate enough to be smuggled in the first place. In just the last few years, the government has also put a moratorium on the sponsorship of parents and grandparents, made it legal to pay temporary foreign workers 15 per cent less than other workers, and raided women's shelters in an attempt to deport individuals.

It is clear that this government has a much broader agenda than the 59 cents per Canadian they claim they will save from denying health benefits to refugees and refugee claimants. Providing care to this vulnerable group is becoming increasingly difficult as public policy is used to further systematically marginalize them, rather than providing them the support and services they need to flourish. I can only hope that the outrage that occurs in response to these increasingly cruel policies will be enough to reverse them and prevent those that the government no doubt has up its sleeve.♦

Ritika Goel is a family doctor and public health professional with Toronto's Inner City Health Associates. Follow Ritika on Twitter @RitikaGoelTO.

The full list of "safe" countries is: Australia, Belgium, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Slovak Republic, Slovenia, Sweden, UK, USA.

This blog post was originally published December 14. 2012 on Huffington Post Canada. For more information, including updated tips for providers see Dr. Goel's blog at righttohealth.ca

TRADE AGREEMENTS: WILL THE COMPREHENSIVE EUROPEAN TRADE AGREEMENT (CETA) TIE OUR HANDS PERMANENTLY ON AFFORDABLE DRUGS?

Correspondence between the Medical Reform Group and Prime Minister

November 19, 2012
Hon. Stephen Harper
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2
By fax: (613) 941-6900

Dear Prime Minister:

The Medical Reform Group has been active now for over 30 years with the goal of enhancing access to high quality health care services and improving the health of all Canadians. We have championed universal, public, not-for-profit health care provision because it remains the most cost-effective way to ensure the best health outcomes. We have been on record as well over the years opposing extra-billing and participating in innovative policy and program change to achieve that goal.

We write today to express our strong opposition to any concessions in the Canada-European Union Comprehensive Economic and Trade Agreement (CETA) negotiations on drug patents or any other measures that would delay access to affordable medicine for Canadians.

The higher prices in Canada for new brand name drugs are already costing us at least an additional $2billion a year. The provisions in the CETA on patent extension would add a further $1billion annually. Why reward bad behavior and broken promises?

We need to take drug patents out of secret trade negotiations and develop a new patent regime that actually delivers benefits to Canadians.

Access to essential medicine and access to generics are key elements in a sustainable public health care system.

Mr. Prime Minister, Canada also needs to negotiate a carve-out for health care that says "nothing in the CETA shall be construed to apply to measures adopted or maintained by a party in relation to the health sector or public health insurance".

Canadians don't want their health care traded away.

Sincerely,
Gordon Guyatt, OC, MD, FRCPC
For the Medical Reform Group

December 4, 2012
Dr. Gordon Guyatt
Medical Reform Group
P.O. Box 40074
Toronto, Ontario M6B 4K4

Dear Dr. Guyatt:

I would like to acknowledge receipt of your correspondence addressed to the Prime Minister, in which you raised an issue that falls within the portfolio of the Honourable Christian Paradis, Minister of Industry.

Please be assured that your comments have been carefully reviewed. I have taken the liberty of forwarding a copy of your correspondence to Minister Paradis. I am certain that the Minister will wish to give your views every consideration.

Thank you for taking the time to write.

Yours sincerely,
M.F. Bustos
Executive Correspondence Unit

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:

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Please specify areas of interest and expertise:

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Telephone _____
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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

WONG DECISION

Members may remember updates in earlier issues of the newsletter that the College of Physicians and Surgeons of Ontario has been conducting a discipline proceeding of Dr. Roland Wong, a Toronto family doctor, on the basis of a citizen complaint.

The basis of the complaint was that Dr. Wong's conduct in recommending patients for the Special Diet Allowance, once part of Ontario's social assistance provisions constituted professional misconduct.

The discipline committee found that Dr. Wong failed to maintain an appropriate standard of practice by not maintaining proper patient records or assessing patients sufficiently to justify his OHIP billings.

A decision about the penalty for the misconduct will be the subject of a separate hearing, early in the new year, at which time the details of the decision should be released. ♦

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

Please visit and comment on our NEW 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]