
Medical Reform

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A CANADIAN PHYSICIAN'S PERSPECTIVE ON THE U.S. HEALTH CARE DEBATE

Ritika Goel

These past few months, we've all watched in amazement, amusement and dismay at the ongoing debate over health care reform south of the border. It has been difficult indeed to sift through the videoclips of screaming town hall hecklers and references to death panels to find any true substance to this debate.

Frequently, we hear rants of a government takeover of health care in Canada and are made to perceive that, as Canadians, surviving our brutal dictatory pro-rationing and anti-patient choice system is a miraculous feat. The majority of U.S. know instinctively to dismiss these allegations as, in fact, the current American health care system rations and it certainly doesn't leave patients much choice.

In today's America, those who don't have insurance are rationed into the 'no health care' pile without much choice, and those who do have insurance are frequently rationed into the 'bankruptcy' pile without much choice. The rest either have the highest, most costly form of insurance that actually pays for your health care when you get sick (what an intriguing concept!) or do not mind paying a few thousand dollars to get care fast and plenty.

Unfortunately, these few often happen to be the policymakers in charge. Those among them who see the hypocrisy in this and try to better the system do so while encountering great resistance.

For those of U.S. who are tired of the dramatizations that are so characteristic of any attempt at discussion in the United States, this is a chance to take a look at the hard issues. We will attempt to discern the truths and comparisons that are so deeply buried within the wild rhetoric.

The current status of American Health Care

As of 2008, the National Health Interview Survey found the

number of Americans uninsured at the time to be 17 per cent of the population or a whopping 43.6 million people! That alone is greater than the entire population of Canada! Add on to that an estimated 25 million adults deemed to be underinsured by their plans (as of 2007) which is up 60 percent from 2003.²

A landmark study by Harvard University found that at least 46.2% of personal bankruptcies in the U.S. in 2001 were due to medical bills. The follow-up to this study, published this August, 2009 in the American Journal of Medicine shows that in 2007, health care expenses accounted for an astonishing 62 per cent of the personal bankruptcies. Even more remarkable, is that the majority of these bankruptcies were filed by those with middle-class incomes and three quarters of them were actually insured.³

The U.S. spends 15.3 per cent of their GDP on health care, a distant first, with second being Switzerland at only 11.6 per cent (Canada spends a meager 9.8 per cent in comparison). With all this spending, one would hope they at least have better outcomes, but in fact, in 2004, the U.S. ranked 24th out of 30 OECD

INSIDE

Editorial Notes	2
Rachlis on US.....	6-7
Responding to National Post.....	7
Primary Care Reform.....	8
Bill 179.....	9
Lessons from the UK.....	10-13
Releases.....	14
Mid-Term Assessment.....	15-17
Poverty Reduction.....	17-18, 20

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(continued on page 3)

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Editorial committee this issue: Gordon Guyatt, Janet Maher

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

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

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

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

EDITORIAL NOTES

Janet Maher

When we have not been overwhelmed with debates of health care reform in the US, a main preoccupation of the media for much of the summer of 2009 has been whether or not the recession we finally acknowledged late last year, is over. A close second is whether or not we might have yet another federal election this fall.

Perhaps the bigger and more stressing question is whether the jobs that have disappeared now for a million Canadians will ever be back, and what the consequences will be for families who have not faced. When the election talk comes again, it will be important to examine platforms for the kinds of solutions they do and do not offer.

The good news for many members in Ontario was to see a candidate for CMA president they could wholeheartedly support--and who has recently been confirmed as president-elect, to take office in the summer of 2010.

In addition to his clear support for accessible high-quality publicly funded health care for all, Jeffrey Turnbull has a record for action on many of the access and equity issues that have motivated the Medical Reform Group for 30 years now.

We expect that his presidency will not be an easy one, but we wish him well and will follow his progress with critical support.

Featured in this issue of Medical Reform is an assessment of the US health debate by family medicine resident Ritika Goel, one of the leaders of the Students for Medicare, described in our last issue. Also included is an opinion piece on the same subject published in the LA Times by Michael Rachlis.

A little overdue, but well worth waiting for is an interview with Steering Committee member Irfan Dhalla on his experience in 2007-08 at the London School of Economics. We'll be encouraging more of his analysis of health care reform in the UK in the coming months.

You will also see a commentary by Steering Committee member Shelley Sender on the effects of the current version of primary care reform in Ontario, as well as a brief summary of the Ontario Government implementation of its health access and equity agenda--clearly still a work in progress. ♦

A CANADIAN PHYSICIAN'S PERSPECTIVE ON THE U.S. HEALTH CARE DEBATE (continued)

countries in terms of life expectancy at birth (Canada ranks 9th).

The U.S. is also only one of three OECD countries (alongside Mexico and Turkey) to have any less than 97 per cent of its population covered with some form of health insurance (be it public or private), at a measly 86.5 per cent having some form of coverage.⁴

A CBS poll released June 20, 2009 shows that 72 per cent of Americans actually support a public option to compete with private insurance.⁵ Based on the above statistics, this comes as no great shock as the current system clearly leaves much to be desired.

Comparisons to Canada

Before the 1970's and the vision of Tommy Douglas was carried out, the Canadian health care system did not look so different from that of the U.S. Both were a mixture of private and public funding, for-profit and not-for-profit delivery and both left many uninsured. We paid approximately the same per person, and had similar health indicators. In 1972, the whole of Canada had finally taken on a public health care system to provide access to physician and hospital services to all through a single payer.⁶

Taking two countries that are otherwise quite similar and then having this fundamental shift in policy has allowed for a large scale experiment that, if anything, only proves the merits of a publicly funded system. Since the time of implementation of Medicare in Canada, there has been a great divergence of both expenditures and outcomes between the two countries.

Increasingly, the cost of the American health care system has skyrocketed as have their numbers of uninsured. At the same time, Canada has surpassed the U.S. in our life expectancy, and has lowered infant mortality. The bottom line is that we spend less money for better outcomes.⁶

A comparison of the two systems suggests that Canadians get a better value for our health outcomes because we do not have a large bureaucratic system designed to decide who can and cannot access health care. In 1999, the U.S. was estimated to have spent 31 per cent of all its health care spending on overhead. This is compared to only 1.3 per cent of spending on overhead in the public system in Canada, similar to the 2 per cent overhead spent on the administration of the U.S. publicly funded health care program for those over 65 – Medicare.⁶

The other issue is that in the U.S. is the lack of regulation of the insurance system. It is set up in such a way that there is a disincentive to provide insurance to those that need it or to provide care to those who try to access it. There is no regulation preventing such detrimental decisions – regulations that exist in most OECD countries where a private insurance sector exists.

Not only this, but the majority of Americans get their health coverage through their workplace meaning they are left at the mercy of the cost-cutting strategies of the employer who has an incentive to purchase health care with the lowest premiums to minimize their own spending and maximize their own profits.⁶

The Case of Shona Holmes and Other Misrepresentations

A discussion of the U.S. health care debate cannot be held in Canada without clarifying the case of Shona Holmes. Ms. Holmes, a 31-year-old woman from Waterdown, Ontario has become the darling of the Republican party by instilling fear into the average person of a potential government takeover of health care. Shona's widely promoted television ad (produced by a group called Patients United Now) features the opening statement "I survived a brain tumour, but if I had relied on my government for health care, I'd be dead. I am a Canadian citizen." This is followed by ominous music and a deep voice proclaiming that in government-run health care, "care is delayed or denied" and "many drugs and treatments are not available because government says patients aren't worth it".⁷

Ms. Holmes presents herself as having had a brain tumour that would have killed her in the amount of time she was asked to wait to see a specialist. She chose instead to fly to the Mayo Clinic where she racked up a bill of \$100,000 in investigations and treatment that she is now trying to get OHIP to pay for. Her diagnosis, stated clearly on the Mayo Clinic's website, was that of a benign Rathke Cleft Cyst which can surely cause difficulty, but certainly not of the life and death situation she has portrayed.⁸

The other major 'analysis' of the Canadian system was one performed by Senator Mitch McConnell who chose as his case study, Kingston General Hospital. He proclaimed that the "bureaucrats who

(continued on page 4)

A CANADIAN PHYSICIAN'S PERSPECTIVE ON THE U.S. HEALTH CARE DEBATE (continued)

run Canada's health care system" make patients wait 340 days for knee replacements, 196 days for hip replacements and three months for breast cancer surgery.

An embarrassing follow-up interview on CNN with Dr. David Zelt, KGH's chief of staff reveals that these numbers are wild overestimates, with the reality being 109 days for knee replacements, 91 days for hip replacements and 23 days for breast cancer surgery. These numbers are also not the average but in fact the time by which 90 per cent of patients waiting will have gotten the procedure done so the average would be even lower.⁹

There have of course been several other amusing and incredibly embarrassing claims that have been made and soon disproven. Another of note, although unrelated to Canada, but an attack on public health care nonetheless is the mention of Stephen Hawking.

An editorial in Investor's Business Daily stated that Mr. Hawking "wouldn't have a chance in the UK where the National Health Service would say the life of this brilliant man, because of his physical handicaps, is essentially worthless." They of course failed to realize that Mr. Hawking is a British citizen and has received all of his care from the NHS. In its defense, the renowned physicist stated, "I wouldn't be alive today if it weren't for the NHS. I have received a large amount of high quality treatment without which I would not have survived."

As a follow-up, IBD stated that Mr. Hawking was a bad example and stated, "Hawking is a renowned theoretical physicist,

university professor and best-selling author. It is doubtful any National Health Service bureaucrat would cut him off."¹⁰

Key Features of the Proposed Reform

While each day the newest version of proposed reform changes, there are basic principles that we can look at of the reform initially proposed by the House of Representatives. The bill they released on July 14, 2009 was called the "America's Affordable Health Choices Act".

The key features of this proposed reform are:

1. For the insurance companies – regulation! Under the proposed legislation, insurance companies may no longer deny or refuse to renew care to anyone. Further, they cannot specifically exclude treatment for pre-existing conditions and cannot drop coverage unexpectedly when it is needed most. This should combat one of the largest hypocrisies of the American health care system – once you are known to need health care, you are denied it.¹

2. For the individual – mandated participation! The proposed reform will 'require' people to get insurance, or else they will be taxed. The tax may be waived for those who are in dire straits and still do not get insurance.¹¹

3. For the employer – encouragement to provide good insurance! Every employer is to pay at least 65 per cent of the premium for an employee. If the employee turns down the employer

chosen health plan to go for the health insurance exchange, the employer has to pay 8 per cent of the employee's salary as tax. If no coverage is being offered, the employer must pay the 8 per cent to the employee directly. Small businesses that provide health coverage will get tax credits.¹¹

4. Who will pay for all this?

The proposed reform will increase taxes for the top 1.2 per cent of earners, starting at individuals making more than 280,000 per year and couples making more than 350,000. The surcharge starts at 1 per cent tax for those between 350-500,000 and goes up to 5 per cent for those making over a million dollars per annum.¹¹

5. CHIP, not quite OHIP - The

"public option." The proposed "public option" as it is commonly referred to, or CHIP (Community Health Insurance Plan), would be available to any individual who does not have adequate or affordable insurance.

While commonly equated to Canadian insurance, this is NOT a single payer health insurance plan as we have in Canada.¹¹ Americans would have the option of choosing this government funded plan and this would not be a fallback system where everyone is covered as is the case in many two-tier systems around the world. Advocates for a single payer system, including the Physicians for National Health Program are skeptical of the proposed public option and feel it does not go far enough.

(continued on page 5)

A CANADIAN PHYSICIAN'S PERSPECTIVE ON THE U.S. HEALTH CARE DEBATE (continued)

They state that the public option will capture only about 9 percent of the administrative savings that a single-payer system would generate. This is based on the fact that doctors would still have to deal with the multiple insurers, as they do now, which is one of the most substantial costs in the system. Further, PNHP is concerned that the insurers will now try to cherry-pick the young, healthy patients and delay and deny those with legitimate health needs.

The Current Status of Negotiations

As time goes on, we anxiously await the bill proposed by the Senate Finance Committee, a bipartisan group of three democrats, and three republicans headed by Senator Max Baucus. Unfortunately, a closer look at the distribution of donations from the health care sector has found that the top recipient of money is none other than Senator Baucus.

Between 2003 to 2008, Senator Baucus collected \$3 million from the health and insurance sectors – an estimated 20 per cent of the total health sector contributions! Health sector donors include insurance companies and drug companies both of which have an interest to oppose a public option.¹² Given this pressure and under the table negotiation, it comes as no surprise that the Senate Finance Committee is expected to completely do away with the public option on the pretense of promoting a 'bipartisan' bill that republicans would support.

Why Do We Care About this in Canada?

The obvious and truthful answer is that we care about the American people. We want them to get the health care they and everyone deserves as a human right. We also want to see put to an end the hypocrisy of the world's most powerful industrialized nation that is unable to even properly care for its own citizens while clearly having ample means to do so.

The other important reason we care, especially as Canadians interested in health policy, is that the debate in Canada is always ongoing. Any change in the U.S. system will no doubt be used as a lens to view our own debate in Canada. One of the large issues with a two-tier system in Canada is that we are situated in a position that NAFTA would permit any American insurance companies to 'expand their market' into Canada were they given the chance. Given the disastrous situation they have created in a highly unregulated situation in the US, this is far from ideal.

For these reasons, as well as the inability to look away, much the same as the feeling one gets when witnessing a road traffic accident, we continue to follow the ongoing chaos down South and try to make sense of it all. ♦

Notes:

¹"FastStats." [cdc.gov](http://www.cdc.gov). April 2, 2009. Centers for Disease Control and Prevention. August 12, 2009. <<http://www.cdc.gov/nchs/FASTATS/hinsure.htm>>

²Schoen, Cathy, Collins, Sara and Kriss, Jennifer. "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007." *Health Affairs*. Vol 102 (June 2008): w298-w309.

³Himmelstein, David U., Thorne, Deborah, Warren, Elizabeth, Woolhandler, Stefie. "Medical Bankruptcy in the United States, 2007: Results of a National Study." *The American Journal of Medicine*. August 2009. <http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf>

⁴"Health at a Glance 2007 – OECD Indicators." [Oecd.org](http://www.oecd.org). Organisation for Co-operation and Economic Development. <<http://www.sourceoecd.org/healthataglance>>

⁵"Poll: Most Back Public Health Care Option" CBS News. June 20, 2009. <<http://www.cbsnews.com/stories/2009/06/19/opinion/polls/main5098517.shtml>>

⁶Angell, Marcia. "Privatizing health care is not the answer: lessons from the United States" *Canadian Medical Association Journal*. October 21, 2008; 179 (9).

⁷ *Patients United Now*. <<http://patientsunitednow.com/>>

⁸"Shona Holmes." [Mayoclinic.org](http://www.mayoclinic.org). Mayo Clinic. August 17, 2009. <<http://www.mayoclinic.org/patientstories/story-339.html>>

⁹Bash, Dana and Jansen, Lesa. "Reality Check: Canada's Government Health Care System." CNN. July 6, 2009. <<http://www.cnn.com/2009/POLITICS/07/06/canadian.health.care.system/>>

¹⁰"Health Care Here and Over There." *Investors.com*. Opinion Section. August 12, 2009. <<http://www.investors.com/NewsAndAnalysis/Article.aspx?id=503233>>

¹¹"America's Affordable Health Choices Act Section by Section Analysis." House Energy and Commerce, Ways and Means, Education and Labour. July 14, 2009.

¹²Eggen, Dan. "Industry Cash Flowed To Drafters of Reform Key Senator Baucus Is a Leading Recipient." *Washington Post*. July 21, 2009. <<http://www.washingtonpost.com/wp-dyn/content/article/2009/07/20/AR2009072003363.html>>

A CANADIAN DOCTOR DIAGNOSES U.S. HEALTHCARE

Michael Raehlis shows how the caricature of 'socialized medicine' is used by corporate interests to confuse americans and maintain their bottom lines instead of patients' health.

Universal health insurance is on the American policy agenda for the fifth time since World War II. In the 1960s, the U.S. chose public coverage for only the elderly and the very poor, while Canada opted for a universal program for hospitals and physicians' services. As a policy analyst, I know there are lessons to be learned from studying the effect of different approaches in similar jurisdictions. But, as a Canadian with lots of American friends and relatives, I am saddened that Americans seem incapable of learning them.

Our countries are joined at the hip. We peacefully share a continent, a British heritage of representative government and now ownership of GM. And, until 50 years ago, we had similar health systems, healthcare costs and vital statistics.

The U.S.' and Canada's different health insurance decisions make up the world's largest health policy experiment. And the results?

On coverage, all Canadians have insurance for hospital and physician services. There are no deductibles or co-pays. Most provinces also provide coverage for programs for home care, long-term care, pharmaceuticals and durable medical equipment, although there are co-pays.

On the U.S. side, 46 million people have no insurance, millions are underinsured and healthcare bills bankrupt more than 1 million Americans every year.

Lesson No. 1: A single-payer system would eliminate most U.S. coverage problems.

On costs, Canada spends 10 per cent of its economy on healthcare; the U.S. spends 16 per cent. The extra 6 per cent of GDP amounts to more than \$800 billion per year. The spending gap between the two nations is almost entirely because of higher overhead. Canadians don't need thousands of actuaries to set premiums or thousands of lawyers to deny care. Even the U.S. Medicare program has 80 per cent to 90 per cent lower administrative costs than private Medicare Advantage policies. And providers and suppliers can't charge as much when they have to deal with a single payer.

Lessons No. 2 and 3: Single-payer systems reduce duplicative administrative costs and can negotiate lower prices.

Because most of the difference in spending is for non-patient care, Canadians actually get more of most services. We see the doctor more often and take more drugs. We even have more lung transplant surgery. We do get less heart surgery, but not so much less that we are any more likely to die of heart attacks. And we now live nearly three years longer, and our infant mortality is 20 per cent lower.

Lesson No. 4: Single-payer plans can deliver the goods because their funding goes to services, not overhead.

The Canadian system does have its problems, and these also provide important lessons. Notwithstanding a few well-publicized and misleading cases, Canadians needing urgent care get immediate treatment.

But we do wait too long for much elective care, including appointments with family doctors and specialists and selected surgical procedures. We also do a poor job managing chronic disease.

However, according to the New York-based Commonwealth Fund, *both* the American and the Canadian systems fare badly in these areas. In fact, an April U.S. Government Accountability Office report noted that U.S. emergency room wait times have increased, and patients who should be seen immediately are now waiting an average of 28 minutes. The GAO has also raised concerns about two- to four-month waiting times for mammograms.

On closer examination, most of these problems have little to do with public insurance or even overall resources. Despite the delays, the GAO said there is enough mammogram capacity.

These problems are largely caused by our shared politico-cultural barriers to quality of care. In 19th century North America, doctors waged a campaign against quacks and snake-oil salesmen and attained a legislative monopoly on medical practice. In return, they promised to set and enforce standards of practice. By and large, it didn't happen. And perverse incentives like fee-for-service make things even worse.

Using techniques like those championed by the Boston-based Institute for Healthcare Improvement, providers can eliminate most delays. In Hamilton, Ontario, 17 psychiatrists have linked up with 100 family doc-

(continued on page 7)

A CANADIAN DOCTOR DIAGNOSES U.S. HEALTHCARE (continued)

tors and 80 social workers to offer some of the world's best access to mental health services. And in Toronto, simple process improvements mean you can now get your hip assessed in one week and get a new one, if you need it, within a month.

Lesson No. 5: Canadian healthcare delivery problems have nothing to do with our single-payer system and can be fixed by re-engineering for quality.

U.S. health policy would be miles ahead if policymakers could learn these lessons. But they seem less

interested in Canada's, or any other nation's, experience than ever. Why?

American democracy runs on money. Pharmaceutical and insurance companies have the fuel. Analysts see hundreds of billions of premiums wasted on overhead that could fund care for the uninsured. But industry executives and shareholders see bonuses and dividends.

Compounding the confusion is traditional American ignorance of what happens north of the border, which makes it easy to mislead people. Boilerplate anti-government rhetoric does the same. The U.S. media,

legislators and even presidents have claimed that our "socialized" system doesn't let us choose our own doctors. In fact, Canadians have free choice of physicians. It's Americans these days who are restricted to "in-plan" doctors.

Unfortunately, many Americans won't get to hear the straight goods because vested interests are promoting a caricature of the Canadian experience. ♦

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HEALTHY CITIZENS START WITH HEALTHY DOCTORS

Letter to the Editor of the National Post Re: Female Doctors Hurt Productivity, May 20th, 2009.

This story highlights Dr. Mark Baerlocher and colleagues' one-dimensional argument that attributes access problems in the Canadian health care system to female physicians' working fewer hours in direct patient care than their male colleagues.

The cause of Canada's doctor shortage will not be found in its gender demographic, nor will the solution be achieved by simply increasing medical school enrolment to accommodate the difference in hours spent on patient care by men and women physicians. Rather, we need to reorganize the way in which we deliver health care on a systemic level to improve overall physician efficiency. For example, integrated family medicine practices that include physicians, nurse practitioners, nurses, pharma-

cists, social workers and other allied health professionals provide faster and continuous care. If we are to improve patient accessibility to physicians in Canada, we need to transform the ways in which we spend our work hours, not simply the number of hours spent working.

Instead of segregating women in the medical profession and scapegoating them for inefficiencies, the medical community should be conscientious enough to recognize that all physicians are realizing the importance of achieving a balanced lifestyle. Over the last two years, both male and female physicians have reduced their weekly work hours to avoid "burnout" in our overstretched system.

It is time for the medical community to leave behind the tradition-

al model of health care that is only sustainable by overworked and overstressed physicians, and instead invest time in helping to create a healthy and integrated population of physicians so that they can offer high quality patient-centred care. ♦

Letter published May 26, 2009 by Iva Vukin and Farah Manji, Class of 2010; Dr. Barbara Lent, associate dean, equity and gender issues, and faculty health; Dr. Carol P. Herbert, dean, Schulich School of Medicine & Dentistry, The University of Western Ontario.

REIMBURSEMENT FOR PRIMARY CARE PHYSICIANS: IS CAPITATION THE ANSWER?

Rachelle Sender, PhD, MD, CCFP comments on Ontario's implementation of primary care reform

The Medical Reform Group has long championed reimbursement models based on capitation. For example, in a 1986 policy statement (MRG Resource Allocation Fact Sheet 6) the MRG stated that, “ a universal capitation-based system with the appropriate safeguards is most likely to provide the efficient, high-quality primary care that Ontario citizens need.”

Since 2001, the Ontario Ministry of Health and Long-Term Care has indeed moved to implement such a system with the introduction of an alphabet-soup of blended, capitation-based primary care reform models, most recently FHO's (Family Health Organizations) and FHT's (Family Health Teams). At present, the capitated rates paid are based exclusively on patients' age and gender.

New research by Richard Glazier et al (Capitation and enhanced fee-for-service models for primary care reform: a population-based evaluation, *RH Glazier, J Klein-Geltink, A Koop and LM Sibley, CMAJ 180 (11): 1113-1119*) provides

some support for the view that capitated models may encourage 'cherry-picking', making it more difficult for the sickest patients to find family physicians.

Using an administrative database provided by Ontario, Glazier and his colleagues compared physician and patient characteristics in two primary care models, a capitation model and an enhanced fee-for-service model. Glazier found that the capitation practices had fewer sick patients, provided less after-hours care, had higher use of emergency department services and enrolled fewer new patients. Both models were skewed towards patients with higher income (comparative data from CHC's, which tend to serve patients of lower socioeconomic status was not available). It appeared that differences in practice characteristics between the two models was largely pre-existing and not due to conversion to capitation reimbursement models.

There is also anecdotal evidence of increased 'cherry-picking' by Ontario primary care physicians through the use of patient interviews

to screen out high-needs patients. It would be interesting to know whether such interviews are more common in capitated practices. Both the CPSO and the MRG have recently released statements condemning this practice.

I believe that there is a need to adjust present primary care models to ensure that individuals with chronic physical or mental health conditions and/or those from a lower socioeconomic status can find a family physician.

One obvious approach is to adjust the capitation system so that the rates paid are adjusted for chronic health conditions and socioeconomic status; as Glazier stated in an interview with Andre Picard (*Globe and Mail, May, 26, 2009, pL4*), “ in countries where capitation models are widely useddoctors are paid more to care for those with chronic diseases and the poor and those incentives work”.

In addition, CHC's need to be expanded and more primary care physicians should be offered the option of Alternative Payment Plans (APP's), which pay an hourly rate for work, often with marginalized populations. ♦

CONCERNS ON BILL 179

The MRG Steering Committee sent the following letter to the Minister of Health and Long-Term Care on August 20th, 2009. Standing Committee hearings have recently been announced for the end of September.

Hon. David Caplan
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, Ontario M7A2C

Re: Bill 179, Regulated Health Professions Statute Law Amendment Act, 2009

Dear Minister:

I am writing on behalf of the Medical Reform Group, a voluntary association of physicians and medical students committed to the maintenance and enhancement of publicly funded health care for all in our province regarding Bill 179 which you introduced in the spring session.

We wholeheartedly support the amendments which, we believe, support a team-based approach to care which is long overdue. We also expect that revision of the scope of practice of many licensed providers will facilitate and ease many of the bottlenecks around routine procedures that have often slowed good care.

We do continue to have a concern, however, with the potential for increasing disparity in access in the implementation of the bill, and are therefore seeking your commitment to honour the spirit as well as the letter of the Commitment to the Future of Medicare Act, an early achievement of your predecessor, the Hon. George Smitherman, in 2004.

In particular, we are seeking an assurance that where services and procedures currently performed by physicians continue to be covered without charge to patients if and when performed by other providers or in settings other than hospitals and physicians' offices. ♦

Sincerely,



Gordon Guyatt, MD, FRCPC

SOME LESSONS FROM THE UK

In the summer of 2009, MEDICAL REFORM editor, Janet Maier, had a chance to speak informally with Irfan Dhalla on his experience as a graduate student in the United Kingdom. Here is a slightly edited version of their conversation.

JM: Thanks again for agreeing to talk to me about the lessons you learned in London and the rest of the UK. I wonder if you might start off telling me why you went to the UK there and then, why you went when you did?

Dhalla: Well, I was fortunate to be able to choose between studying health policy in the UK, Canada or the United States. I wanted to see was a different health care system up close and I also wanted to study one that I thought might provide some useful lessons for Canada.

Many of the problems the American health care system faces, as you know, are very different from the problems that the Canadian health care system faces. I thought the problems that the UK health care system was trying to deal with at the time were more similar to those we face here. I also had a feeling that there were some things that we could learn from the UK system.

On a personal level, I had finished my clinical training in Canada and was in that period where I had some freedom before settling down in a practice, so the timing was right.

JM: I'm interested to find out what opportunities for direct observation you had, because that was obviously one of your objectives. Did you actually get to practise while you were there?

Dhalla: No, I didn't practise. It's very difficult for Canadian-trained physicians to practise in the United Kingdom, just as it is difficult for physicians trained in other countries to practise here. I did spend a few half days in various hospitals. Not very much really. I observed the primary health care system primarily as the parent of an infant but also as a husband and as a patient myself.

We actually had a brief experience with a private clinic. We wanted to get flu shots, which as you know are recommended for everybody in Ontario, but are not available for free in the UK except for individuals who are at particularly high risk. The visit to the private clinic was interesting for several reasons.

First of all, the markup on the vaccine was immense. I think we paid the equivalent of 50 or 60 dollars each to get vaccinated. Second, the clinic was very reluctant to immunize our daughter, since she was very young. But of course she stood to benefit the most from receiving the vaccination! So it was, in a way, an illustration of the kind of "cream-skimming" that we often hear about with private clinics.

Then I spent the last four or five months of the year at the National Institute for Health and Clinical Excellence. This is the organization that formulates guidelines in the UK. It also decides which drugs and health care technologies will be used within the NHS and which ones should not be funded. That was a very interesting experience, particularly because we don't have an entity quite like NICE in Canada.

And then finally I had an opportunity to speak with many doctors, nurses and other people who work within the health care system,

and of course many people who use the health care system, and also the opportunity to speak with a few high level governmental advisers and managers.

JM: And what did you learn? I'm imagining that you might have learned a few things.

Dhalla: That's a good question. Each health care system has strengths and weaknesses. There's no doubt about that. I don't think one health care system has all the answers. I think one overarching lesson is that it is very difficult to cherry-pick solutions from other health care systems because things have a way of evolving in response to local factors. Moreover, the cultures and contexts into which health systems are embedded can be very different.

Even two countries like the United Kingdom and Canada, which on the face of it appear to be very similar, nevertheless have quite different cultures. One example of this as it pertains to healthcare is that the British view the NHS quite differently there than Canadians view Medicare.

JM: What do you mean by that?

Dhalla: Well, first of all virtually everybody in the United Kingdom seems to accept that there should be no charges for physician or hospital services within the NHS. This acceptance isn't nearly as widespread in Canada, where despite the Canada Health Act we continue to see user fees and the co-mingling of insured and uninsured services.

There's also a different culture among professionals, in particular

(continued on page 11)

SOME LESSONS FROM THE UK (continued)

among physicians. Physicians in Canada tend to view themselves as free agents, whereas physicians in the United Kingdom tend to view themselves as part of the NHS.

To give you a very concrete example of this, physicians in the United Kingdom will do work for NICE, without asking for extra money, because they're paid a salary by the NHS. In contrast, in Canada, physicians who sit on committees that perform some of the functions that NICE performs are paid for those services.

So there is this sense that physicians in Canada are independent contractors and that we should charge for our services, as opposed to in the UK, where physicians seemed to me to be more likely to view themselves as being part of the NHS.

I should talk a little bit about primary care in the UK. I knew before I went that the UK was reputed to have a very good primary care system. That really became very clear once we were there. Everybody has a family doctor. If you don't have a family doctor, as we didn't when we arrived, you just go to your local family practice and they just sign you up. There are really no questions asked, nobody asks about what your health needs will be, nobody looks at how busy the practice is, they just sign you up if you live in the area.

And family doctors work in groups alongside nurses and other health care professionals. I think they do a much better job of using the most appropriate provider. Nurses or nurse practitioners will do most of the screening manoeuvres, preventive health exams, dietary counselling, and so on, which are activities that take up a lot of time for many family doctors in Canada.

Another big difference between primary care in the United Kingdom and Canada is that virtually all primary care offices in the United Kingdom have electronic health records, so they're very quickly able to generate lists of patients who have not had certain screening procedures done and send out letters or make telephone calls.

Most GPs in the UK also do house calls if patients can't come to the office. And there's always some form of evening and weekend coverage. So the primary care system in the United Kingdom is I would say much more comprehensive than it is in Canada. Also in the last few years, the Government has started to measure the quality of care provided by each primary care practice and links a significant portion of pay to performance on those measures.

This pay-for-performance system has only been around for a few years and it has become clear that the Government has overpaid, but nevertheless I was very impressed by the fact that they can measure performance in so many dimensions at the individual practice level, make that information publicly available, and then tie compensation to that performance.

JM: I wonder if it makes sense to ask you to talk about the extent to which something like that might be transferable here. It sounds in principle like it shouldn't be a problem.

Dhalla: That's where I think it's not quite as easy as some people might think. For one, we don't have the history of using nurses and nurse practitioners as much in primary care. So we don't have as many individuals who are trained to do those kinds

of jobs. We could train people of course, but we couldn't do it overnight.

Second, our family doctors are still largely paid on a fee for service basis, and as long as family doctors are paid primarily on a fee for service basis, a lot of the things that go on in the United Kingdom are very difficult to do in Canada.

Clearly there are obvious benefits to having electronic health records in every family practice, even if those electronic records don't communicate with each other and even if they don't communicate with the hospitals' electronic records. This is something we should be able to do relatively easily. Clearly there are also benefits to the government being able to view reports from those data so that the government has a sense of what performance is like, on a practice by practice basis.

JM: I wonder if you can talk about any of the other kinds of comparisons that we often make around access, around equity, how the system works for patients. You've talked a bit about each of these but I wonder if you'd crystallize your response to each of those in a sentence or two.

Dhalla: Well, I would say it's very difficult to make broad comparisons because first of all, health care is very local. And second, different people have different expectations, so wherever you go in the world you will find people who love their family doctor or their local hospital and you will find people who don't love their doctor or who don't love their hospital.

But everybody in the UK has a family doctor and there is universal

(continued on page 12)

SOME LESSONS FROM THE UK (continued)

coverage for prescription drugs, so there's no doubt that the UK would outperform Canada on some basic measures of access and equity. And at the moment, primarily because of a large infusion of public funds over the last decade or so, waiting lists in the NHS are at near historic lows and are probably lower in most areas than they are in Canada. As a result, the number of people purchasing private health insurance is declining.

Whether the UK can continue to have short waiting lists in the face of the global economic slowdown remains to be seen. And it's also worth noting that historically waiting lists in the NHS have been longer than they have been in Canada, and that may be as a result of the private tier that exists in the UK.

JM: So how does the system work for patients?

Dhalla: From a primary care standpoint the system works very well for patients. Everybody has a family doctor. You phone and make an appointment or drop in the same way you would here and if you're elderly or disabled or find it hard to visit your family doctor's office, your family doctor will come to your home, which doesn't happen in Canada as much as it probably should.

If you have a minor health need that you want to have dealt with urgently, and your family doctor can't see you that day, you can go to a walk-in clinic, I think most of the walk-in clinics run 24 hours a day and unlike in Canada the clinic there are not staffed by physicians, they're staffed by nurses, or nurse practitioners.

JM: And they are fully part of the NHS?

Dhalla: Yes. I had a personal experience with one which I am happy to share. I had what I thought was strep throat and it was late in the afternoon and my family doctor's office said that they could only see me the next morning, which obviously would have been fine, but I thought it would be more convenient just to go to a walk-in clinic and I was also interested to see what the experience would be like. So I walked over to one and I waited probably about thirty to forty-five minutes.

I saw a nurse, she agreed that I probably had strep throat, she reached into a cabinet, took out some Penicillin and gave it to me. And I had to pay a few pounds on the way out because there are user fees for prescriptions drugs if you're completely healthy and under the age of 65, and that was it.

These walk-in clinics probably keep a lot of the minor complaints out of the emergency departments. I should note that they won't do things like refill prescriptions or see people for chronic illnesses. They insist that people see their family doctors for those kinds of problems to ensure continuity of care.

I should also note that the experience of patients in hospitals in the UK is not always great. Certainly you hear some complaints in that area, even though they have taken steps to improve services that the hospitals are providing, particularly in terms of emergency department wait times. Despite this criticism, I am not sure there is a health care system anywhere in the world where patients have uniformly good experiences when they are in hospital; we're just not there yet in terms of figuring out how to deliver patient-centred care.

One thing I did want to talk a little bit more about is NICE. I was very impressed with the work of NICE. I don't think that what NICE does is appreciated as much in Canada or even in the UK for that matter as it should be. Their approach to technology, assessment, and guideline development really is the worldwide gold standard.

Their guidelines are about as free from industry influence as can be imagined; they're widely used by practitioners and most importantly they're supported by an implementation program. For example a physician told me that she prescribed a drug to a patient that wasn't recommended by the NICE guidelines, or actually that the NICE guideline had recommended against. And a few days later she received a phone call from a manager in her local health authority asking her why she prescribed this drug in this particular situation. She wasn't really able to give a convincing argument for why the drug was necessary.

Now that doesn't mean that the patient shouldn't have received the drug. But what the manager did say was that they would rather that the patient see a specialist to determine whether that drug was in fact appropriate.

Now the physician who told me this story told me because she was a little bit annoyed that her decisions were being questioned. But as an outside observer it struck me as a very rational process. If you are going to treat patients in a way that isn't recommended by guidelines, it probably is appropriate for somebody to look over your shoulder and make sure you're making reasonable decisions.

(continued on page 13)

SOME LESSONS FROM THE UK (continued)

JM: That brings me to my other question of what it's like for the professionals who work in it?

Dhalla: Frankly I think that physicians there are a little bit beleaguered. The UK health care system is much more managed than our system. It's not always managed well, but it is managed more, so doctors in the UK complain a lot about bureaucrats, having to meet targets and being forced to be efficient, and being asked to do things they don't want to do. There's no doubt that both hospital doctors and primary care physicians in Canada have much more freedom than doctors in the United Kingdom.

JM: So, I wonder if there's anything we should be learning from the U.K, or are there lessons we might want to avoid—beyond what you've already talked about.

Dhalla: Well one thing we didn't really talk about was the whole issue of the public system contracting out certain procedures or operations to the private sector. This does go on in the U.K, although it's not nearly as widespread as some advocates for privatization in Canada would have us believe. I think it's on the order of 1 or 2% of NHS surgical procedures. I'm not including here the procedures that are privately paid for—about 10% of the population has private health insurance. What I'm talking about procedures that are “on the NHS”.

The patient doesn't pay anything for a procedure, they go to a private clinic for it, and the private clinic sends the bill to the NHS. Unfortunately there aren't enough publicly available data to definitively

answer the question about whether these private clinics are performing better or worse than the private hospitals.

That being said, the fact that the government has been slow to release the data and the fact the private providers themselves haven't been able to put forward a compelling argument showing that they are more efficient than the public sector providers, suggests that private providers have probably been less efficient. The data that have been publicly released or that have been obtained through freedom of information requests also support the claim that private providers have been less efficient.

So I think that's one significant lesson. I think if policy makers in Canada want to consider contracting out publicly funded services, I think they need to very carefully study the U.K example and look very critically at what people in government and others say about it. Obviously people in government have an interest making it look like the experiment has worked. There are certainly claims that this strategy has increased choice and improved efficiency but it's impossible to find rigorous data to support those claims.

I think that trying to develop organizations like NICE, either at the provincial or federal level would be good for the Canadian health care system. It wouldn't be very expensive, I think NICE costs the UK about thirty or forty million pounds per year—which is about fifty pence for every man, woman and child—and the savings could be quite significant.

If you take one example and compare treatment for high cholesterol in the UK versus treatment for

high cholesterol in Canada, what's happened in the UK is that the NICE guidelines have encouraged the use of the less expensive drug, simvastatin and so most patients in the UK are treated for high cholesterol with simvastatin. In Canada, where we don't have an organization like NICE, a very large proportion of patients are treated with atorvastatin, which is much more expensive. And atorvastatin is so expensive that even switching just a fraction of patients to a cheaper drug could probably pay for NICE many times over.

JM: That gives an important context for the discussion. Is there anything else you want to add? Would you recommend others go to the U.K for this kind of experience?

Dhalla: I would. I think it would be good for Canadian physicians and other health care professionals to spend as much time as they can in a variety of different countries, including the United States. I think we could learn a lot by sending some of our staff and policy makers to other countries for extended periods of time, then having them come back and share with us what they've learned. ♦

INCOMING CMA PRESIDENT'S APOCALYPTIC RHETORIC UNFORTUNATE, MISLEADING, SAY DOCTORS

The Medical Reform Group today expressed concern that the incoming CMA President, Dr. Anne Doig, may be falling into an unfortunate trap.

We have suffered over 20 years of 'health care in crisis' rhetoric from right wing advocates of privatized two-tier medicine," said MRG spokesperson Dr. Gordon Guyatt.

"There are better ways of working toward improved health care than using language that inappropriately frightens the Canadian public."

"We all agree that the system is imploding, we all agree that things are more precarious than perhaps Canadians realize," Dr. Doig has told The Canadian Press.

"We wonder who the 'all' is to whom Dr. Doig is referring," said

another MRG spokesperson, Dr. Ahmed Bayoumi. "Doctors are appropriately concerned about challenges facing Canadian health care, but few would agree that the system is imploding. The Medical Reform Group certainly does not."

In fact, recent initiatives have effectively addressed waiting lists in areas such as joint replacement and cataract surgery, and many other initiatives of demonstrated effectiveness, if widely adopted, could further improve care.

Those strategies include an expansion of dedicated publicly funded not-for-profit outpatient or short stay facilities for orthopedic procedures, more effective wait list management, and more effective integrated chronic care management.

"We welcome Dr. Doig's practical suggestion to accelerate the move to electronic medical records," Dr. Bayoumi continued, "but have serious reservations about moves to funding mechanisms that have failed in Britain."

"Dr. Doig's rhetoric could play into the for-profit delivery, two-tier health care agenda of the prior two CMA presidents, Drs. Ouellet and Day," Dr. Guyatt concluded. "If you want to see a health care system that is really imploding, look south of the border. Americans are spending 17 per cent of their GDP on health care and leaving 46 million uninsured. That's the direction we don't want to go."♦

Released by the Medical Reform Group August 16, 2009

DOCTORS WELCOME CMA LEADERSHIP CHANGE

The Medical Reform Group today offered congratulations to Dr. Anne Doig, incoming Canadian Medical Association President, and Dr. Jeff Turnbull, incoming President-elect.

"The MRG views this change in leadership as extremely positive," said MRG spokesperson Dr. Gordon Guyatt. "We are looking forward to a reversal in direction for the CMA – policies that are more in line with the values of the Canadian people."

"We are particularly enthusiastic about Dr. Turnbull's election," said another MRG spokesperson, Dr. Ahmed Bayoumi. "It is a great relief to have a CMA President-elect

who is fully and unequivocally committed to universal, publicly funded health care delivered by not-for-profit providers."

The previous two CMA Presidents, Dr. Brian Day and Dr. Robert Ouellet were both longstanding private clinic owners and outspoken advocates of privatization.

"Dr. Doig's views on strengthening, rather than undermining universal Medicare, have not been expressed as clearly as those of Dr. Turnbull," Dr. Bayoumi noted. "We very much hope that she will reverse the destructive events of the last two years, and lead the CMA in a direction that is consistent with the best interests of the Canadian public."

Health economic analysis has demonstrated that publicly funded health care is not only more equitable, but also more efficient, than privately funded care. Systematic reviews of high quality observational studies have demonstrated lower death rates in not-for-profit versus for-profit hospitals and outpatient facilities."

"In contrast to the previous two CMA Presidents, Dr. Turnbull's views are consistent with both the evidence and with the values of the Canadian people," Dr. Guyatt concluded. "We hope the same proves true of Dr. Doig."♦

Released by the Medical Reform Group August 19, 2009.

A MID-TERM ASSESSMENT OF THE MCGUINTY GOVERNMENT ON HEALTH

Janet Maher

As we approach the half-way mark in McGuinty's second term, it is worthwhile reviewing their progress in the agenda that brought them to power in 2003 and a successful re-election campaign in 2007. In particular, given the deterioration in the economy and the diminished prospects for many Ontarians who had expected to retire in relative comfort, it is worth evaluating how well the government is keeping its commitment to maintain the health of the less fortunate.

The Liberal platform of 2003 on health was expansive. In addition to addressing many long-standing health human resource hotspots with a combination of education and practice incentives, there were promises to

- ◆ Pass the Commitment to Medicare Act, making two tier Medicare illegal,
- ◆ Set limits on wait times,
- ◆ Stop privatizing MRI/CT clinics and expand public MRI/CT services,
- ◆ Invest in home care and make it an essential part of Medicare,
- ◆ Add generic drugs to drug formulary as soon as they are approved,
- ◆ Ban ER closures and open 1,600 beds to relieve pressure on ERs,
- ◆ Provide guaranteed multi-year funding for hospitals.

Additional platform planks focused on health promotion initiatives including mandatory physical education in schools, support for community sports and recreation and an aggressive anti-smoking strategy, and improvements in family and oth-

er leaves to accommodate family realities relating to both children and elders.

According to the Ontario Hospital Association, staffed beds of all kinds in Ontario hospitals actually declined from 31,646 in 2003 to 30,284 in 2008 (www.healthsystemfacts.com), while between 2003 and 2007, the registered nursing work force increased by 5,600 (see www.cihi.ca/cihiweb/en/statistics_RN_2007_ss2_e.html).

Wait times for the 5 designated procedures are inching downward, and some modest steps have been taken on the home care agenda and expanding imaging services. Some further investments have been made in primary care and information management with the implementation and expansion of family health teams and attempts to advance electronic recordkeeping. But much remains to be done.

The 2007 platform on health was more modest, and phrased in terms of a continuation of the 2003 agenda in the following terms:

- ◆ Expand our progress on wait times to emergency room visits, children's surgery and general surgery
- ◆ Deliver access to a family doctor to 500,000 more Ontarians
- ◆ Deliver 50 more Family Health Teams over the next four years, targeting areas like rural and northern Ontario, where doctors are harder to find
- ◆ Create 100 more medical school spaces and accredit more internationally trained doctors
- ◆ Hire 9,000 more nurses, meet our goal to have 70% of nurses

working full-time, guarantee jobs for new nursing grads, invest in healthy work environments for nurses and establish 25 more nurse-led clinics

- ◆ Invest \$100M in growth funding for hospitals in our fastest growing communities.

What have they done to meet their targets?

Although some headway has been made on health service provision, it remains to be seen how much new investment in health human resources and expanding service capacity will actually be accomplished in this mandate.

In fact, the centrepiece of the 2007 provincial election campaign focused more on the social determinants of health than the direct provision of health services. In December of 2008, the government earned the kudos of many in the advocacy community with a plan to reduce child poverty in the province by 25 per cent by 2013.

This was to be accomplished through full implementation of a provincial children's benefit, modest increases in some other tax benefits and allowances, as well as investments in housing, child care and other social and recreational services. Children and Youth Services Minister Deb Matthews, the lead minister on the poverty reduction strategy acknowledged inadequacy of the current social assistance rates structures, with a promise for comprehensive legislative review within the current mandate of the government.

(continued on page 16)

A MID-TERM ASSESSMENT OF THE MCGUINTY GOVERNMENT ON HEALTH (continued)

Bill 8, Commitment to the Future of Medicare

The campaign rhetoric on the Commitment to the Future of Medicare Act, proclaimed in 2004, was to render two tier Medicare illegal. Indeed, the preamble of Bill 8 acknowledges the government's commitment to the prohibition of two-tier medicine, extra-billing and user fees in accordance with the principles of the Canada Health Act, it also 'recognizes' that pharmacare for catastrophic drug costs is important to the future of the health care system, and that access to community-based health care, including primary health care, home care based on assessed need and community mental health care are cornerstones of an effective health care system.

As it transpired, however, the enforceable provisions of the bill were more modest. Part I provides for the Ontario Health Quality Council, which has provided important leadership with recommendations around maintaining access for marginalized and sicker Ontarians—food for thought for the government or the day, but not yet implemented.

Part II on accessibility, outlaws extra-billing for any service in the OHIP schedule and provides for recovery of any money so paid, as well as fines to providers ranging up to \$25,000. The legislation does not ban block fees for non-insured services, but requires clear disclosure to patients. Other provisions in this section provide for additional regulations on administrative charges and the formula for determining such charges.

Part III, on Accountability Agreements foresees the devolution

of funding decisions to Local Health Integration Networks and provides a process for accountability agreements setting out performance and other expectations between the Local Health Integration Networks and health resource providers (a generic term for health services including acute care hospitals, community and long-term care facilities, but excluding physicians).

While many advocates lobbied for Bill 8, to include a prohibition on hospital construction through public-private partnerships (P3s), begun by the Tories, this did not happen. The Liberals relented in part by introducing what they called Alternative Finance and Procurement (AFP) arrangements, which introduced some limitations on the P3 model. Nonetheless, as featured in the 2008 report of the Ontario Auditor General, cost overruns and increasing service gaps persist in Brampton, the site of the first of the P3 hospitals, and one of the fastest-growing communities in the province.

Poverty Reduction

Each year of the McGuinty mandate since 2004, the provincial budget has also brought modest supports for pilot projects in health promotion—including targeting childhood obesity, mental health, diabetes control and smoking cessation and the like. However, rather than coordinating these initiatives with existing public and community programming, many of the initiatives are being implemented piecemeal, often in a whole new bidding process. The extraordinary efforts of Dr. Hazel

Stewart of Toronto Public Health to expand emergency dental services for youth and seniors, have met with some limited success despite public and media support. Some of the larger-ticket items, for example, provincial pharmacare, remain on the drawing board.

The December 2008 announcement of a provincial commitment to poverty reduction initially elated the community advocates who had worked so hard on addressing the needs of the most marginalized since the 1996 Harris cuts. Although many advocates, including the Medical Reform Group, urged the government to expand the focus on child poverty to include all those living in poverty, all supported the government initiative, which reinvigorated the lobby's effort to see results in the 2009 budget.

As part of its strategy, the government did advance the implementation of the provincial child benefit by a year, adding an extra \$500 per child annually to the budgets of many low income families, but eliminating several small allowances, such as those for winter clothing and back to school supplies for school age children. However, calls (including support from the Ontario Health Quality Council and the Toronto Medical Officer of Health) for an increase in regular social assistance rates for adult recipients, either directly or through the \$100 food supplement, were met with a nominal increase of 2 per cent (about \$15 monthly) over the previous year, and the promise that legislative review still to come would provide a better basis for an over-

(continued on page 17)

A MID-TERM ASSESSMENT OF THE MCGUINITY GOVERNMENT ON HEALTH (continued)

haul of the rate system which has been essentially unchanged since 1988.

In the spring of 2009, the Hon. David Caplan, the new Minister of Health and Long-Term Care, introduced bill 179, which is likely to be passed into law soon after the legislature returns in the fall. While the aim of the bill, providing more flexible scopes of practice for many of the regulated health professions, is laudable, it is not clear at the moment whether procedures once performed by doctors and/or in hospitals, and therefore covered in the OHIP schedule of benefits, would continue to be covered when offered by other providers and/or outside hospitals.

Advocacy for and on behalf of those living in poverty has always had to contend with the preference of policy analysts to focus on the so-called 'deserving' poor—children, elders and to some extent, those with disabilities. And so it has been in the current campaign, despite mounting evidence through the efforts of bodies like the government's own crea-

tion, the Ontario Health Quality Council, of the need to address the compromised and chronic health issues of the most marginalized—single working-age adults for the most part unlikely to be fully participating members of the work force because of chronic conditions or mental health issues.

What's ahead? And where can we effectively intervene?

With fixed date elections, we can anticipate the need of government and opposition parties to begin this fall to design election platforms for the 2011 election. In our work with coalitions, such as the 25 in 5 Network for Poverty Reduction and the Ontario Alternative Budget Working Group, we are increasingly called on to assist in advancing the policy debate by providing clear and concise evidence, sometimes more repetitively than we would like to, on the potential impacts of one or another policy direction for access and for long-term costs to individuals and to the system. Several of our members

have assisted in providing expert advice and consultation in legal cases relating to social assistance benefits.

We have also contributed recently to legal challenges which focus attention on the need for change. In the spring of 2009, the campaign to eliminate the 3-month OHIP waiting period for newcomers was eliminated for convention refugees, though it remains for other immigrants and migrants from other provinces. We expect in the fall to pursue collaboration with injured workers' advocates on focusing attention on injured workers who all too often end up in poverty as their WSIB benefits are curtailed when they are not able to return to work.

In addition to the benefits often achieved for individuals, all of these situations provide educational opportunities and we will be following the legislative review on social assistance with particular interest. We will also continue to work with the community coalitions to focus attention on the government record as 2011 rolls around. ♦

HEALTH INSURANCE A HUMAN RIGHT?

Janet Maher

Last issue we reported that the Ontario Ministry of Health had agreed to eliminate the 3-month waiting period for OHIP for refugee claimants, enhancing access for one of several groups frequently denied health services in Ontario. Unfortunately, there remain other groups who continue to be excluded.

Toronto lawyer Andrew DeKany has taken on the case of a

client who, in spite of having worked and paid taxes in Canada for the past 10 years, now finds herself very ill, without status in Canada, and without insurance as a result of not having completed the landing process when she arrived.

As a result, she is not eligible for OHIP, and it appears at first glance, nor is she eligible for the Interim Federal Health Benefit (feder-

ally sponsored coverage normally available to immigrants) while their immigration status is being adjudicated.

Ontario Legal Aid has agreed to fund the legal challenge of the refusal by the federal government to allow her Interim Health Benefit coverage, essentially because she cannot afford the immigration processing (continued on page 18)

FAIR PAY AND REDUCED DELAY

Janet Maber, from files

Fair Pay and Reduced Delay is the title of a brief recently received from the Criminal Lawyers Association of Ontario.

The brief summarizes a review of 30+ years of criminal law representation from the legal aid program, noting not only the inefficiencies resulting from chronic underfunding of legal aid defence counsel, but the implications for access by some of the most vulnerable--those living in poverty, those with mental illness or developmental delays who are inordinately represented in the population of the incarcerated--in our community.

The result of the failure to adjust legal aid rates to reflect the cost of living and to keep pace with what is paid to other actors in the criminal justice system (crown counsel or expert witnesses, for example) means that representation of the vulnerable is left to the least experienced members of the profession. Further, limited resources result in delays which affect not only the counsel and the accused but also police and other witnesses and court personnel who must make themselves available repeatedly for court appearances at

which they will not testify for one reason or another.

The author of the brief, Frank Addario, also observes that there are more matters proceeding now without counsel or with less than adequate counsel than a generation ago. This causes bottlenecks at both pre-trial and trial stages of the process, and increases the risk of wrongful convictions and unjust sentences. Addario suggests that a fair rate for routine work would currently be in the range of \$120 to \$160 per hour and that rates in the range of \$250 per hour might be required to attract more experienced defence counsel.

The other recommendations in the brief include:

- ◆ In addition to increasing the rate, amend the maximum tariffs for long or complex cases. This would be expected to attract more senior counsel, and to result over the long term in fewer delays and fewer wrongful convictions.
- ◆ Improve accountability for legal aid funds with clear and fair audit and review processes for overbilling and abuse
- ◆ Provide for ongoing tariff reviews

- ◆ Consider incentives to reduce pre-trial appearances and permit early resolution.

- ◆ Expedite intake processes for legal aid to reduce the number of appearances

- ◆ Enhance legal education and mentoring opportunities for defence counsel to promote best practice

- ◆ Consider teleconferencing and other flexible options for pre-trials where their use could reduce the time or number of appearances required for resolution

- ◆ Coordinate and schedule courts more effectively to reduce the number of appearances which use up justice resources

- ◆ Increase mechanisms to address the issues outside of court.

The lobby being mounted by Addario and the Criminal Lawyers Association focuses on public education on the effects of the neglect of legal aid and the implications for access to the right to a fair trial. ◆

For more information, contact Frank Addario at (416) 979-6446 or faddario@sgmlaw.com

HEALTH INSURANCE A HUMAN RIGHT? (continued)

fees required to regularize her status.

This case and other rights challenges we have reported on bear monitoring. One of the components of the provincial poverty reduction strategy which remains to be implemented is a comprehensive review of social assistance benefits and allowances.

The Ontario government has been promoting its health equity agenda with some pride. It will be important to ensure that these laudable health measures are not limited or contradicted by inadequate social policy. ◆

For more information, contact the office at medicalreform@sympatico.ca

FALL MEETING PLANS

Our recently-amended constitution provides for a single members' meeting annually, and the Steering Committee has recommended that this happen in the fall of each year.

The Steering Committee will meet shortly to decide on an

agenda for the 2009--the 30th annual meeting.

Watch our website for more information on the fall meeting and anniversary plans.

If you would like more information on MRG media activities, consider joining our electronic news

list. You can do this by sending a message to medical-reform-news@googlegroups.com ♦

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
- \$60 Affiliate (out of province) physician Intern / Resident / Retired / Part-time Organization
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RECESSION SIDELINES POLICES TO ADDRESS WOMEN'S POVERTY: STUDY

Canada still has shockingly high rates of women's poverty but the recession seems to have sidelined anti-poverty policies, says a new study by the Canadian Centre for Policy Alternatives (CCPA).

Women's Poverty and the Recession reveals even after taking into account government transfers and tax credits, almost one-quarter (24%) of Canadian women raising children on their own and 14% of single older women are poor, compared to 9% of children.

"Child poverty seems to win political points but Canadian governments are ignoring the very real and private struggle of women on their own who are living in poverty at shockingly high levels," says CCPA Research Associate Monica Townson.

Among the study's findings:

◆ Women raising children on their own are almost five times more likely

to be poor than two-parent families with children.

◆ The poverty rate of older women on their own is almost 13 times higher than seniors living in families.

◆ Women who work full-time, year round earn only 71 cents for every dollar earned by men.

◆ About 40% of employed women work in precarious jobs that are generally poorly paid with little or no job security and no benefits such as pensions.

◆ Only 39% of unemployed women compared with 45% of unemployed men are receiving EI benefits.

◆ Women account for 60% of minimum wage workers, but minimum wages in all provinces are less than \$10 an hour.

The study is critical of recent federal government policies that have helped contribute to women's poverty.

"Since coming to power in 2006, the Harper government has seriously undermined progress towards reducing women's poverty in Canada," Townson says. "Among a long list of policies, Harper has restricted pay equity, refuses to fix EI to prevent more unemployed women from falling into poverty, and cut funding for early learning and child care."

Provincially, the study notes new poverty reduction strategies are underway but, to date, they fail to address the pressing problem of women's poverty. ◆

Released by the Canadian Centre for Policy Alternatives September 1, 2009. For a link to the study, go to www.policyalternatives.ca

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