Medical Reform

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PRELUDE TO A SYSTEMATIC REVIEW OF ACTIVITY-BASED FUNDING OF HOSPITALS: POTENTIAL EFFECTS ON COST, QUALITY, ACCESS, EFFICIENCY, AND EQUITY

Karen S. Palmer, Danielle Martin and Gordon Guyatt

The Canadian approach to funding hospitals may be on the verge of a monumental change. Until recently, hospital funding has been based predominantly on global budgets, but health care system decision-makers throughout the country are now seriously considering— and some are already adopting—an alternative funding model referred to as activity-based funding (ABF).

In contrast with global budgeting, ABF pays hospitals per episode of care for each patient served. In simple terms, the money follows the patient. Under this system, hospital services are classified prospectively into clinically meaningful "bundles" of care that use similar levels of resources. These bundles take into account patient characteristics such as diagnosis and complexity, along with anticipated volume and intensity of care. Different jurisdictions use various terms to describe these bundles of services; for example, they might be called "diagnosis-related groups" in the United States and "health-resource groups" or "case-mix groups" in Canada.[1] Various costing methods are used to set a "price" for the bundle of services provided to each patient during a hospital stay.

The historical roots of ABF lie in the US health care system. In the late 1970s, rising health care costs in the United States coupled with economic stagnation forced policy-makers to investigate financing reforms for Medicare (the publicly funded program for patients aged 65 and older). Starting in 1983, the government implemented a prospective system of hospital payment based on DRGs; rather than simply paying hospitals whatever they charged to treat Medicare patients, the new model paid hospitals a predetermined, set rate based on the patient's diagnosis.[2] Since then, other countries have adopted, and adapted, this approach as the basis for all or part of their hospital funding systems.

In Canada, where reductions in government revenues are spurring a desire to "bend the cost curve" in health care, ministries of health are "focusing more on efficiency, value for money, and accountability"[3] while they simultaneously look for ways to increase access to hospital care and maintain quality of care.[4] ABF has captured the imagination of some policy-makers and advo-

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

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

We hope this issue provides some interesting reading members might not usually get to. Among the items for consideration:

The lead article by Palmer, Martin and Guyatt is a very preliminary assessment of the material available for a systematic review of activity-based funding (ABF) in hospitals, a trend so far resisted in Canada, although there are signs that it is getting a hearing in some areas as health authorities seek options to 'get more value for money." Time will tell how realistic that option is; in the meantime, we hope that by the next issue of MEDICAL REFORM, some of the early results of the systematic review will be ready for reporting.

A second item, co-authored by Petch and Martin, and originally published in the online blog Healthy Debate, highlights issues around moving care out of hospitals, exposes one element of the debate which we hope to treat in a round-table discussion which will be the format for the spring members' meeting. The other main document or series of documents for that discussion will be the McMaster Health Forum Evidence Brief which can be found on the McMaster Health Forum website.

We have no doubt that the April 9, 2014 round table will provide for a lively discussion among academics, policy makers and activists—keep in touch for specific time and place early in the new year.

Focusing more directly on poverty and poverty reduction, we were pleased to see that Ontario reported a decrease in child poverty in the first five years of its first poverty strategy—closer to 10% than the 25% anticipated, but nonetheless an achievement on the tail of the 2008 recession. Some are concerned though, that this achievement has been at the cost of other poverty reduction targets and the lack of a larger strategy to 'raise all ships at the same time.'

In that regard one document worth a closer reading is the November 2013 report from Social Planning Toronto, which looks at what cities can do in areas as diverse as employment, income support, housing, community supports and transit, to improve opportunities for all. You will also find a short news item from member Andrew Pinto on the randomized controlled trial he and colleagues have designed to collect data on the impact of adding an income-focused health promoter to the St. Michael's family health team.

From yet another perspective, a new publication from the Canadian Centre for Policy Alternatives is also worth considering Tax is not a four letter word is a collection of articles by a broad range of economists and policy makers, which puts the microscope on something that should be obvious—that the high quality services we have enjoyed for decades are only available because of the forethought of an earlier generation who sought to ensure stable revenue for universal programs—through a tax system that maximized access by collecting and distributing revenue as fairly as possible.

You will also see in this newsletter evidence of the activism of some Toronto members on proposals to expand the island airport by lifting the long-time ban on jets on the waterfront. Although the decision has been at least temporarily deferred, city councillors have yet to reaffirm the ban. ♦

Erratum: In issue 162, we mistakenly identified the firm promoting the Island Airport expansion as WestJet. The company seeking permission to expand facilities and lift the long-standing ban on jets at Billy Bishop Airport is actually Porter Airlines.

cates as one potential component of hospital reform.

Opinion is divided within the Canadian health care policy community as to whether ABF would help us achieve any of the putative benefits originally achieved in the United States and in other nations that subsequently adopted variations on the ABF theme, or whether the risks would outweigh the benefits.

What are those alleged benefits? Enthusiasts point to evidence that ABF can reduce costs per episode of care or improve efficiency,[4,5] reduce length of stay,[6] and reduce wait times;[7] they also claim that a culture change, by which patients are seen not as cost centres but as revenue generators,[4] is needed in Canadian health care. To elaborate, by fostering competition for patients between hospitals, ABF theoretically provides hospitals with financial incentives to increase efficiency. Under ABF, hospitals retain any surplus in funding above their expenditures per case, but must absorb any losses if expenditures exceed reimbursement. The other potential benefits arising from these financial incentives include stimulating productivity[8] (i.e., increasing patient throughput, leading to improved access and reduced wait times), increasing transparency[9] and accountability in hospital spending, and moderating cost growth.[10]

But what about the potential adverse consequences of introducing ABF? The detractors of this funding method point to evidence that it leads to the rapid discharge of sick patients into community settings that may be unprepared to care for them,[11] provides an incentive to "upcode" and thus "game" the system,[12] creates a perverse focus on "profitable" over "unprofitable" patients and procedures, with negative implications for equitable access to care,[13] and increases overall costs to the health care system[14,15] in the absence of global caps on spending.[4]

Under ABF, the incentive to spend less, on average, per patient could encourage the premature discharge of sick patients from hospital, which might increase rates of preventable readmissions[16] and of postdischarge mortality. Spending less per patient might also compromise the quality of care patients receive in hospital or lead hospitals to eliminate unprofitable services (such as trauma units[17,18]) or, conversely, in order to "make a profit," to unnecessarily admit and potentially overtreat patients who could otherwise be cared for as outpatients.[4,19] There is also a concern that a "cherry-picking" or "cream-skimming" effect could reduce equitable access to care if hospitals cater preferentially to profitable patients.[20] Similarly, since more treatment- intensive case-mix groups warrant a higher reimbursement rate, there is an incentive to selectively code patients as being sicker than they really are.[21,22] Any efficiencies gained through ABF may be undermined by the increased administrative spending required to cope with coding and monitoring demands, as well as by the transaction costs of implementing ABF. Another worry is that by breaking care into "saleable units"[23] ABF will facilitate the introduction of private, profit-driven delivery of care.

Both ABF enthusiasts and detractors can point to evidence to support their claims, and each line of reasoning follows a logical narrative that can be persuasive to policy-makers. However, in making their case, each group selects the international experiences that are consistent with their narrative, rather than attempting to understand the evidence as a whole.

British Columbia and Ontario are leading the Canadian movement toward ABF as an alternative to, or in combination with, global budgets. Results from a British Columbia study published early in 2013 indicated that one anticipated benefit, increasing patient through-put, had not been achieved: the authorities."[24] Such findings raise questions about whether the supposed benefits of ABF play out when this model is implemented in the real world.

The international literature on ABF consists of research studies and non-systematic reviews[8,9,25–28] without, so far, a single systematic review. Health care researchers are convinced that "systematic reviews of research evidence constitute a more appropriate source of research evidence for decision-making than the latest or most heavily publicized research study."[29] Policy- and decision-makers should rely on robust evidence to make well-informed decisions about how best to finance and deliver health care. "Evidence-informed" policy-making is characterized by the "systematic and transparent access to, and appraisal of, evidence as an input into the policy-making process."[30] Yet, in the absence of a thorough and systematic approach to understanding the impact of ABF on cost, quality, access, efficiency, and equity across multiple health care systems and at different times, Canadian policy-makers continue to make decisions based upon only selected evidence. The limited reviews available may well reflect biased selections of the available evidence.

Having established the pressing need to review all the evidence

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available about ABF, in March 2012 our research team launched a systematic review to inform Canadian policy-makers about how this funding model affects health care systems around the world. Our systematic search of Canadian and international evidence has demonstrated that there is no shortage of published literature addressing ABF. Of the more than 16 000 potentially eligible titles and abstracts we have screened, 261 studies, representing 64 countries (either singly or in aggregate), provide data on at least one of the cost, quality, access, efficiency, and equity outcomes of interest to our research team. We are now in the process of analyzing data from the eligible studies most germane to the Canadian context.

This commentary is intended to alert decision-makers to the upcoming release of a series of papers based on our systematic review of ABF, in the hope that there will be an appetite for this knowledge at a time when they are being asked to make decisions in its absence.

It would be a shame if Canadian governments moved to ABF only to find later that, for instance, they obtain none of the putative benefits but instead observe premature hospital discharges to an unprepared post-hospital care system and subsequent adverse health consequences to patients. It will be particularly regrettable if, armed with a systematic review of the evidence researchers found "no intervention effect of the ABF reform on the changes in surgical volumes over time in all five health authorities."[24] Such findings raise questions about whether the supposed benefits of ABF play out when this model is implemented in the real world.

Our systematic review will soon provide a more robust evidence base to better inform decision-makers. Until then, it would be imprudent to rush to judgment about the effects ABF may, or may not, have on Canada's health care system. We look forward to releasing our results in the near future and encourage governments to consider the implications of our review in their decisions about hospital funding reforms. ♦

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RESEARCH TEAM AT ST. MICHAEL'S HOSPITAL TO STUDY INCOME-SECURITY INTERVENTION

Andrew Pinto

Social processes that impact the health of individuals have been labeled the social determinants of health (SDOH). These are "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels". Perhaps the most important SDOH is income security, a person's actual, perceived and expected income. Despite strong evidence linking SDOH with health outcomes, interventions to address these factors are rarely found within the Canadian health care system.

We are planning a pragmatic randomized controlled trial that evaluates the impact of an income-focused health promoter. The St. Michael's Hospital Academic Family Health Team has received ongoing funding from the Ministry of Health and Long-Term Care to support this position. The primary outcome is change in patient income over two years. Secondary outcomes include improvements in quality of life, self-rated health and changes in health service utilization. This project will lead to a better understanding of how health professionals can directly address the SDOH within primary care settings.

For further details, contact Dr. Andrew Pinto at andrew.pinto@utoronto.ca. ♦

ANOTHER FACE OF THE MEDICAL REFORM GROUP

In late fall, 2013, editor Janet Maher interviewed member Reed Siemieniuk on his experience as a medical student and resident.

MR: Can you tell me a little about yourself, how and why you decided to go to medical school?

RS: Well I was born and raised in Calgary. I moved out to Ontario initially for University – I was passionate about sports and had an opportunity to play for the University of Waterloo basketball team. During my summers off, I had worked back in Calgary at the Southern Alberta HIV Clinic initially as a "photocopy boy" and then later delved into research. I was struck by the huge uphill social barriers that so many of the patients faced, despite the fact that their health care and medications were provided for free – the dream of combining research and clinical medicine was engrained at that point.

When I had the opportunity to go to McMaster for med school, there was no way I was turning it down. At the time, I was thrilled to have the opportunity to attend a school with a reputation for global health (and the chance to finish in three years). It was an incredible experience and I was able to meet many of the mentors that I still keep in touch with today, including Gord Guyatt, who introduced me to the MRG.

MR: I know you are currently an internal medicine resident? Are you anticipating a sub-speciality? How do those plans shape your approach to medicine? Where do you think it will lead you (if you think it will)?

RS: I'm in my second (of three) years of internal medicine training. The great thing about internal medicine is that really you can have an approach to almost anything that comes through the hospital doors. I love that the broad scope of practice allows internists to go from practicing in the most rural areas to urban centres in the same week. I'm hoping that the breadth of practice is going to allow me to keep sight of the health system as a whole, while still speaking from a perspective with expertise. After medicine, I'm hoping to do a fellowship in infectious diseases – beyond a fascination with the specialty itself, I'm drawn to it because of the opportunities for advocacy. The economically disadvantaged and otherwise vulnerable members of society are afflicted by a disproportionate burden of infectious diseases, including HIV and others; finding and advocating for fixes to the underlying systemic problems are just as important as treating each individual patient. The HIV community has had some inspiring advocacy wins, which really shows the power a group of very passionate people can have.

MR: What experience do you have/what skills do you think you have learned in medical school and elsewhere that shape your analysis of the role of health care and health care providers in society?

RS: It's no secret that health care providers and doctors in particular have a privileged role in society. At the same time, we have the privilege of interacting with people from all parts of society every day. While it took a lot of hard work to get into medical school and through a strenuous residency program, I'm under no illusion in that I recognize that by far the biggest factor in my success was the luck of being born into the right social situation. The biggest difference between myself and many socially-disadvantaged and sick patients is hard luck. I think the biggest learning point for me has been having to face this inequity head-on on a daily basis. Having to face this inequity where I think we have a responsibility to advocate for policies that address the root causes of this inequity.

I've absolutely loved the variety of experiences during my medical training. The great thing about medical school and internal medicine residency is that every month or two I'm working in a different hospital in a different sub-specialty. It means that I have the opportunity of experiencing first-hand the variety of healthcare delivery in Canada -- I get an in-depth view of what works and what doesn't. I think this really gives residents an important and unique perspective in health care policy discussions.

MR: What do you see as the links, if any between health, human rights, poverty, and other social determinants, in general and in your approach to your future as a clinician?

RS: I've heard it a thousand times: an ounce of prevention is worth a pound of cure. Yet despite study after study showing vital health links to the social determinants of health, we continue to under-invest in these problems.

Income inequality is growing faster in Canada than every other OECD country except the United States and its undoubtedly going to have an impact on health. At the same time, Canada's prison population is growing faster than it ever has while crime rates are at an all-time low. I'm worried that these examples, among others, represent worrisome trends in our social structure that will ultimately end up having downstream impacts on health.

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ANOTHER FACE (continued)

As a clinician, of course it's always important to consider the underlying cause of a person's illness, whether its poverty, societal isolation, or other social problems. That being said, it's difficult to address these issues on an individual basis unless we invest in them as a society. That's why I'm so proud to be a part of the Medical Reform Group – we're able to respond to and advocate for a variety of social issues because of their intimate connection with health.

From a more clinical perspective, one project that I've been very passionately involved initiating is a multidisciplinary intimate partner violence screening program for HIV-positive patients. Perhaps naively, I was shocked at the high burden of intimate partner violence and its close link with poor outcomes. It's amazing though, what can be achieved when some of the underlying causes of poor health are addressed: anecdotal and preliminary evidence is showing that our program is having important health benefits. This is one great way that, on a very practical level, I can bridge the divide between social inequities and health.

MR: What do you see as the 2 or 3 main policy issues for current medical graduates? If this is where you are likely to put your energy in the next five years, what do you think your work will look like?

RS: There are a few really important health policy issues for me and medical graduates:

1) Health human resource planning: It seems that there's this fear building up among some residents about finding employment opportunities after graduating. It can be a very emotionally-charged issue, and one that is sometimes used as an argument for two-tiered health care. Realistically, job shortages are isolated to a few specialties in relatively small geographic areas and there still plenty of people that need access to physicians or other healthcare providers. At 2.1 physicians per 1,000 people in Canada, we have the lowest number of physicians per capita of all the OECD countries, while at the same time physicians in Canada receive high remuneration, which may limit a government's ability to expand the physician workforce.

It's also well known that there's a surplus of highly qualified people willing to go through the long process of becoming a licensed physician in Canada. There are already a number of initiatives to increase access to physicians, especially in rural areas, but increasing the supply of physicians to match other OECD countries might be an important piece. Taking all of this together, I think it's time we had a hard conversation about reducing physician income in Canada. We might be able to expand the workforce or invest in other areas if physician income was reduced to more typical levels.

2) Pharmacare: Pharmacare is probably one of the most important health policy issues and certainly one that will only increase in importance. As new and more expensive medications are approved for use in Canada, drug costs for Canadians continue to increase. As a resident, I've seen first-hand the devastating impact that unaffordable prescriptions can have on patients in a different settings: for example, a $20,000+ procedure for a heart attack (with coronary stent) failed and the patient had another heart attack because the patient couldn't afford the much cheaper anti-clotting medication. On a different service, there was a patient who required a prolonged course of expensive in-hospital treatment because they could not afford oral antibiotics that were prescribed when the infection was much better. As a resident I've seen it first hand across the spectrum of medical services: it's absurd that we pay for the physician services and diagnostic testing but not the medications needed to actually treat the disease.

Bulk-purchasing is a fantastic first step to reduce what all Canadians spend on medications and ensure that everyone receives the essential medications they need. The New Zealand Pharmac model shows that it's feasible and will end up saving Canadians millions of dollars.

3) Decriminalizing drug use: One of my passions, in terms of policy advocacy, is the decriminalization of drug use. It's unconscionable to me that as a society we continue to demonize drug users, jailing or fining them in the face of strong evidence that if anything, it only entrenches the problems. It's quite clear that the American-led War on Drugs and punitive drug policy has been a huge failure; yet while the Americans soften legislation, we've hardened our stance.

There is a record number of prisoners in Canada, an increasing proportion of whom are incarcerated on illicit drug crimes. Unfortunately, we're only further entrenching social divides: for example, Aboriginal people make up almost 25% of the prison population but only 4% of the Canadian population overall. Countries like Portugal and others have clearly demonstrated success in reducing harms from illicit drugs by shifting the focus from punitive measures for drug use to health promotion. At risk of losing a huge number of people to the prison system,

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THERE ARE HIDDEN COSTS OF MOVING CARE OUT OF HOSPITALS

Jeremy Petch & Danielle Martin

Connie's story

Connie is a Personal Support Worker (PSW) who cares for seniors and people with dementia in their homes. She is a graduate of George Brown College's PSW program and has been working in home care for the last 10 years.

She makes $16 per hour, but rarely gets paid for more than four hours a day, because most of her time is spent traveling on subways and buses between clients' homes, which are spread across the sprawl of North Toronto. She is paid only $1.50 for travel, even though getting between clients' homes often takes an hour on the TTC. She does not make enough money as a PSW to make ends meet for her family, and so cleans homes when she is not providing home care.

Despite struggling to make ends meet, Connie loves providing home care, and speaks passionately about how she helps her clients live independently. She can't help but wonder, however, why she has to struggle when her former classmates from George Brown with the same training enjoy higher wages and steady hours working in hospitals and nursing homes.

Moving care out of hospitals

Ontario has joined an international trend in shifting health care out of hospitals and into communities, including a planned expansion of home care. Not all patients who occupy hospital beds need acute care and not all patients in long-term care facilities need to be institutionalized. For some of these patients, care can be provided effectively and efficiently in the home.

Moving care into the home is popular with the public. Studies consistently indicate that patients prefer to be cared for at home when it is safe to do so. There is also evidence that unnecessary hospital stays are bad for patients' health. Providing care in the home also raises hopes of substantial cost savings for the government, while simultaneously freeing up hospital resources to focus on patients with acute needs.

If done well, moving care out of hospitals could improve patient care, while reducing health care spending. However, there are hidden costs, both financial and human, of moving care into the home that have received little public attention, including lower wages, riskier work environments and greater burdens on family caregivers.

Lower wages in the home care sector

A major source of expected savings from a shift to home care is lower wages – wages in the home care sector are substantially lower than in the hospital or long-term care sector.

Personal support workers in the home care sector can be paid as little as $12.50/hour compared to hourly rates of $18 to $23 for their hospital-based colleagues. Similar disparities have also been observed for other care workers, including registered nurses.

In addition, home care workers often do not get steady hours, compared with their colleagues in hospitals and long-term care.

The primary driver of lower wages in the community is that there is significantly less unionization compared to the hospital sector. According to Stella Yeadon, a representative for the Canadian Union of Public Employees, this is largely because union organizing is very challenging in the home care sector. Unlike the hospital environment where workers are in a single building, home care workers rarely meet one another. As a result, traditional labour organizing methods have tended to fail in this sector.

According to a report from the Ontario Health Coalition, another historical contributor to lower wages was the Ontario government's procurement policy for Community Care Access Centres (CCAC), which required CCACs to contract out home care services. While competitive bid-

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ANOTHER FACE (continued)

there's an urgent need in to move from reactionary to evidence-based policy.

MR: What implications does this have for advocacy more generally and do you see yourself involved there?

RS: I'm still relatively new to the medical and the advocacy communities and there has been some incredible work building support for these policies. It's an honour to be working with the MRG and tapping into the wealth of experience that the group has. There have been some inspiring successes that I hope to learn from and build on. I hope I can bring enthusiasm for progressive policies forward in both my evolving clinical/academic and advocacy careers. ♦

MOVING CARE OUT OF HOSPITALS (continued)

ding for contracts was somewhat successful in keeping costs down for CCACs, it did so largely by "driving down wages," according to the authors of the report. This procurement policy has been frozen for the last several years, but served to set a historically low baseline for wages in the community care sector.

Healthy Debate contacted a large Ontario provider of home care services regarding the wage disparity between home and hospital care, but the company was unable to provide comment by press time.

Ross Sutherland, co-chair of the Ontario Health Coalition and a registered nurse who has worked in both acute care and home care, worries that turnover as workers leave home care for higher paying jobs at hospitals is bad for patients. "In the community, you need a trusting relationship between a caregiver and a patient," he says, "but trusting relationships need stability, and one of the things we've seen is that when wages are low you get a much less stable workforce. This means patients at home don't always get the continuity they need."

Low wages and limited benefits across an entire sector raise concerns about the possibility of recruiting skilled care workers. "People with the higher education will go where they can get the higher pay," says Sutherland, "this makes a lot of sense to me… I've done this myself, actually." These concerns are offset somewhat by work hours in home care, which tend to be flexible and therefore attractive to some workers. However, since travel time can be extensive and is often uncompensated, low wages could pose real barriers to recruiting and retaining staff.

Worker safety unknown

Another area of concern is worker safety in the home care sector.

Health care workers face substantial health risks as part of their work, due to their exposure to infectious diseases, violence from patients/residents with dementia, allergic reactions from chemical agents, and injuries resulting from lifting patients.

"The home care sector is relatively new, it's grown quickly, and it's relatively invisible," says Cam Mustard, president of the Institute for Work and Health. As a result, there is not currently good Ontario data to determine how safe home care is for health care workers, as compared to delivering care in hospitals or long-term care facilities. "This is a dimension of the expansion of homecare that we're late in realizing the importance of," he says.

There is currently limited data on the occupational health risks of delivering care in the home. However, some care may be riskier in the home, where workers are more likely to be without either backup from other staff or mechanical assistance (such as patient lifts), as compared to workers in a hospital or a long-term care facility.

As home care expands, better data on worker safety in the home will be needed to keep the workforce healthy and safe.

Greater burden on families

Another source of cost savings for the government of moving care into the home comes from having to provide less nursing care, and not having to provide housekeeping, laundry or kitchen services in the home. Where hospitals employ large staffs to provide these services, in the home care sector many of these services are provided by patients' families.

Kim Peterson, vice president of clinical services for the Champlain CCAC, is concerned that there is already too little support for caregivers. Any expansion of home care, she says, "must be accompanied by a major expansion of caregiver supports, including financial support."

Despite its importance, support for family caregivers was notably absent from both Ontario's Action Plan for Healthcare and the year-one update released last month. Support for caregivers is part of Ontario's new Seniors Strategy, but it remains to be seen how much of this strategy will translate into action.

It is also important to recognize that many patients who need home care do not have families to care for them. Charmaine, another home care PSW interviewed by Healthy Debate, says "for most of my clients, I'm all they have. I'm their best friend. But right now the CCAC only pays for me to be with them one, maybe two hours a day. It's not enough – they're alone – there's no one to care for them but me and they need more help."

Expanding home care while maintaining quality

While many patients prefer to be cared for at home, they also want the quality to be just as good as it is in other settings. At the moment, it is not clear that this is the case, and lower wages and riskier environments raise the possibility that the quality of care may be negatively affected as services are moved from hospital to community settings.

And while patients prefer to be cared for at home, this may not be sustainable for their families without

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DOCTORS URGE CAUTION ON IMPACTS OF DOWNTOWN AIRPORT EXPANSION

The Medical Reform Group today calls on Toronto City Council to support Board of Health recommendations that the Toronto Island Airport land be used in a manner that is most supportive of health and consistent with the vision for the Toronto Waterfront. This would go firmly in opposition to the proposed expansion of the airport to include jets.

The Toronto Board of Health's rapid Health Impact Assessment highlights the concerns with current and expanded operations including air pollution, climate change, water quality, safety and enjoyment at the Waterfront. The assessment was completed by the same firm that earlier advised the city to reduce current emissions from transportation sources because of saturation of the airshed with pollutants.

"Even the status quo is a problem for health, meaning an expansion to include jets would be a step in the wrong direction," stated Dr. Miriam Garfinkle, an MRG spokesperson. "The health impact assessment gives us the information we need to make this decision, and city council should certainly vote against an expansion."

"It is regrettable that the health impact assessment was rushed to fit into the timeline imposed by Porter which precludes the consideration of other variables like the runway extension," said Dr. Susan Woolhouse, another MRG spokesperson. She added, "The interests of corporations should not be allowed to trump public health, safety and community well-being, and so we urge the Council to oppose the expansion." ♦

Released December 9, 2013 by the Medical Reform Group, as member Miriam Garfinkle appeared at the Toronto Board of Health. The Board of Health voted unanimously to defer a decision pending more information.

THE HEALTH OF CANADIANS UP FOR SALE IN THE TRANS-PACIFIC PARTNERSHIP DEAL

Canadians are being asked to accept increases in the cost of their medications in a free trade deal with Pacific countries. The negotiations for the Trans-Pacific Partnership (TPP) are ongoing this week behind closed doors in Salt Lake City, but a leaked working copy of the negotiations show that the deal could have drastic implications for drug patent law.

"This deal would be disastrous for Canada. We could end up paying hundreds of millions of dollars more in medication and surgical costs every year," said MRG spokesperson, Dr. Reed Siemieniuk. Currently, drugs are patented for seven years after approval in Canada, but with this deal, the United States is pushing to add three years to that time leaving Canadians paying for expensive brand-name drugs longer, rather than using less costly, equally effective generic drugs.

"We know that these types of patent protections do not generate increased investments by the pharmaceutical industry," noted another MRG spokesperson, Dr. Ritika Goel. "Already 1 in 10 Canadians do not fill prescriptions because of cost. We cannot afford to increase those numbers."

The leaked documents include other worrisome suggestions including allowing patents to be placed on surgical methods and creating legal barriers for public access to clinical trial data.

The Medical Reform Group is a voluntary organization of physicians, residents, and medical students committed to evidence-based healthcare policy. ♦

Released by the Medical Reform Group, November 20, 2013.

MOVING CARE OUT OF HOSPITALS (continued)

more supports for caregivers.

While moving more care into the home may be the right direction for Ontario, the hidden costs of this transition will need to be addressed. Maintaining both a skilled workforce and healthy unpaid caregivers may require additional spending, which might reduce the anticipated cost savings of moving care into the home. The alternative, however, could be a home care system that fails to deliver the quality patients expect. ♦

Reproduced with thanks from www.healthdebate.ca, where the article originally appeared February 21, 2013

MEMBERSHIP FEE INCREASE COMING FALL, 2014

After 15 years at current membership fee rates, the Steering Committee voted in November, 2013 to increase membership fees, effective at the next renewal date, September 1, 2014.

New fees will be $295 for one year and $550 for two years.

Members renewing for 2 years up to September 1, 2014 will be eligible to renew at the current rate of $475 for 2 years.

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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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:
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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

SPRING MEETING

Planning is well under way for a members' meeting, **Wednesday, April 9, 2014** in Toronto—further details on precise location and start time will be available shortly.

This meeting will take place in a round table format, and focus on issues raised for the recently completed Mcmaster Health Forum on specialty clinics in Ontario.

As two of an anticipated four speakers at the round table, we have confirmed Dr. John Lavis, Director, McMaster Health Forum, and Professor, McMaster University and Dr. Danielle Martin, Vice-President of Medical Affairs and Health System Solutions at Women's College Hospital, Assistant Professor in the Department of Family and Community Medicine and the Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, and Past President of Canadian Doctors for Medicare.

Lavis is the lead author of Evidence Brief: Creating Community Community-based Specialty Clinics in Ontario. Hamilton, Canada: McMaster Health Forum, 22 May 2013 and available at the McMaster Health Forum website.

Martin was co-author with colleague Jeremy Petch of the ***Healthy Debate*** article of February 2013, There Are Hidden Costs of Moving Care out of Hospitals, reproduced in this issue of ***MEDICAL REFORM***. .

Please watch our website at www.medicalreformgroup.ca for more information.

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