

MEDICAL REFORM

Newsletter of the Medical Reform Group

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BLOCK FEES UNDERMINE ACCESSIBILITY TO HEALTH CARE: DOCTORS' GROUP CALLS ON GOVERNMENT TO BAN PATIENT CHARGES

Irfan Dhalla and Gordon Guyatt

The Government of Ontario claims commitment to the Canada Health Act, and ensuring that ability to pay doesn't influence access to care. But doctors have found a way around this principle and, so far, Premier Dalton McGuinty and Health Minister George Smitherman are letting them get away with it.

If you are lucky enough to have a family doctor, you may have recently received an unwelcome request. The doctor, or more likely the doctor's receptionist, might have asked you to pay a block fee—an annual payment, levied in advance, for services not covered by your provincial health insurance plan. Block fees are supposed to cover services such as telephone prescription renewals and the completion of summer camp forms.

In theory, patients can opt to pay for uninsured services on an *a la carte* basis rather than *en bloc*. In practice, however, most patients find it very hard to say 'no' when their doctor asks them to pay for services in advance—even if they know they will never need those services.

Even worse, many patients face the threat of losing access to their family doctor if they don't pay a block fee. One doctor's patients were told that their telephone calls would go unanswered unless they paid up. Another doctor's patients were informed they could no

longer make appointments if they refused the annual fee. Everyone agrees that these practices are unacceptable—the important question is how to prevent them.

It's no surprise that the Ontario Medical Association wants to keep block fees regulated as loosely as possible. An OMA representative has said that "Offering block fees can actually improve the pay-as-you-go system...[They force] doctors to be more business-oriented." In fact, block fees have become so popular that a small industry has sprung up to make sure doctors are maximizing their block fee revenue.

But what is surprising, and disturbing, is that the College of Physicians and Surgeons of Ontario, a regulatory body whose duty is to protect patients, has also endorsed block fees. Last month, despite clear evidence that doctors continue to violate the College's existing block fees policy, the College voted to continue to allow doctors to charge these fees. The College's decision comes despite its admission that it has neither the resources nor the intent to actively monitor and enforce the administration of block fees.

The Medical Reform Group, an association of doctors and medical students who believe that all Canadians should have equitable access to high-quality health care, has been trying to persuade the College to put a stop to block fees. With last month's vote, however, the College regrettably put doctors' interests above patients.

Fortunately for Ontarians, under the recently passed *Commitment to the Future of Medicare Act*, the provincial government has the power to regulate block fees—or ban them entirely. The MRG prefers an outright ban—with over 20 000 doctors in Ontario, monitoring the use of block fees would be a significant administrative challenge, and a waste of resources. Moreover, no realistic oversight could prevent physicians from continuing to stretch the rules, and the patients

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

Editorial committee this issue: PJ Devereaux, Bradley MacIntosh, 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.

BLOCK FEES UNDERMINE ACCESSIBILITY TO HEALTH CARE (continued)

most likely to be harmed—the poor and the elderly—are unlikely to complain.

There are useful actions the government could take short of prohibiting block fees. First, the government should insist that doctors who charge a block fee inform OHIP of both the amount of the fee and the name of each patient that is paying the fee.

Second, doctors who charge block fees should provide each patient with government-authorized material outlining the patient's rights. This document should specify that physicians cannot charge patients for the more conscientious provision of an insured service, that physicians cannot charge patients for being more available, and should inform patients how they can complain if they believe their doctor is violating these guidelines.

Third, the government should explicitly ban “boutique medicine”—the

practice of charging large annual fees for extra services and preferential access. Only a small number of doctors in Ontario are using the block fees policy in this way now, but little stands in the way of many more family doctors opening up boutique practices.

In an ideal world, where patients and doctors were on an equal footing, block fees for uninsured services might be acceptable. Until and unless we get there, doctors should recognize that block fees often undermine accessibility. The Government of Ontario must not permit this stealthy erosion of the Canada Health Act. ♦

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COLLEGE OF PHYSICIANS AND SURGEONS SHOULD VOTE DOWN POLICY PERMITTING PATIENT CHARGES

On November 25, the College of Physicians and Surgeons of Ontario will make a crucial policy decision concerning “block fees”—flat fees charged in advance by doctors for services not covered by the Ontario Health Insurance Plan. The Medical Reform Group is now publicly urging the College to ban the practice of charging block fees.

“The College knows that many doctors violate the existing block fees policy,” said Dr. Irfan Dhalla, spokesperson for the MRG. “For example, doctors have asked patients to pay a fee before allowing them to join their practice. Everyone agrees that this is unacceptable. The College has acknowledged that it cannot actively monitor and enforce their block fee regulations. Protecting patients requires the College to ban block fees altogether.”

Under both the current and proposed policies, physicians are allowed to charge patients for uninsured services (e.g., telephone prescription renewals, completing forms for summer camp, etc.) either individually or with an annual flat fee. Under the flat fee policy, patients often pay for services they never use. The College has proposed a new draft policy that allows patients to refuse to pay the fee, and bans physicians from penalizing patients who refuse to pay the block fee.

“The College’s regulations might work in a dream world, but we live in a province with a severe physician shortage,” said Dr. Ahmed Bayoumi, another spokesperson for the MRG. “Patients are terribly dependent on their doctors. It is completely unrealistic to expect patients to risk upsetting their doctors saying ‘no’ to the block fee.”

According to the College, recent violations of the block fees policy include:

- ◆ Doctors charging block fees as a condition of being accepted into a practice
- ◆ Making patients pay for services that are covered by OHIP (for example, requiring payment for a specialist referral)
- ◆ Terminating patients from a practice for not paying a block fee
- ◆ Not responding to telephone messages from patients who refuse to pay the block fee

“Block fees benefit doctors but not patients,” said Dr. Dhalla. “If the College does not ban block fees, they are failing their responsibility to protect the public.”◆

Released November 24, 2004 by the Medical Reform Group

NEARSIGHTED PHYSICIANS REJECT DEAL WITH GOVERNMENT

The Medical Reform Group believes that Ontario doctors have made a serious error in rejecting the deal negotiated with the provincial government.

“The deal was not perfect,” said MRG spokesperson Dr. Yves Talbot. “For one thing, the government and OMA were making health policy without consulting other constituencies. But the policy they were making, particularly the moves toward primary health care reform, was good policy.”

Doctors are by far the highest paid health professionals. Yet, there is

a large income gradient between primary care doctors and specialists. The profession has shown itself incapable of dealing with this problem alone. This deal would have begun to redress the gradient, and potentially make primary care more attractive to young physicians.

“Primary care reform has moved at a glacial pace”, said another MRG spokesperson, Dr. Ahmed Bayoumi. “It’s become evident that the only way to get doctors on board is to give them a financial incentive. This agreement would have provided that incentive.”

The government and the profession now have a big problem. With other health workers being asked to hold demands for wage increases, providing substantial new income to the highest paid workers will be very difficult to justify.

“The government must show its resolve to retain the progressive elements of the agreement the doctors have rejected,” concluded Dr. Talbot. “Ultimately, physicians must consider the public interest, and support the urgently needed restructuring of primary care.”◆

Released November 22, 2004 by the Medical Reform Group.

SMITHERMAN RIGHT TO PLAY TOUGH WITH DOCTORS

The Medical Reform Group believes the Ontario government should move forward with its initiatives to revamp the health care system despite the Ontario Medical Association voting down a contract loaded with incentives to stimulate this vital transformation.

"The OMA negotiators thought they had a good deal for doctors, and a good deal for the people of Ontario," said MRG spokesperson Dr. Gordon Guyatt. "They were right. This deal was defeated because of a highly effective propaganda campaign waged by a small number of misguided physicians."

Doctors are the highest paid health professionals. As usual, this deal gave them more in the way of increases than other health care workers are likely to

get in upcoming negotiations with the government.

"The doctors who rejected the deal are swimming against the tide of progressive change in health care," said MRG spokesperson Dr. Yves Talbot. "Primary care reform has moved at a glacial pace. That's in large part because of resistance of the doctors, and their rejecting the deal is just one more episode in that resistance. It's become evident that the only way to get doctors on board is to give them a financial incentive. This agreement provides that incentive, and it's the first time we have real political will for primary care reform."

The government has a number of options, ranging from imposing the contract against the OMA's will to going back to the negotiating table. The Medical

Reform Group believes the government should consider all of its options, including offering the contract individually to the 40 per cent of doctors who endorsed it or offering the most transformative aspects of the contract to the entire profession.

"The contract had a number of progressive features that would improve patient care," commented Dr. Guyatt. "With the cooperation of the 40% of doctors who voted for the deal, the government should ensure that these elements are put in place as soon as possible." ♦

Released December 2, 2004 by the Medical Reform Group.

SERIOUS LIMITATIONS IN HEALTH CARE DEAL

The Medical Reform Group of Ontario today made severe criticisms of the health care deal between the federal and provincial governments.

"No national home care, no pharmacare, no serious primary care reform, and no end to creeping privatization," said MRG spokesperson Dr. Gordon Guyatt. "This deal is no success."

In 1997 the National Health Forum called for national home care and pharmacare programs. The Romanow report and Senate Kirby reports repeated the calls. "Despite all the new federal money, in 2004 we are as far from national home care and pharmacare plans as ever," said another MRG spokesperson, Dr. Irfan Dhalla.

The current agreement provides some targets in the home care and pharmacare areas, but very little extra money. "In previous agreements, federal and

provincial governments have quickly ignored their targets," Dr. Guyatt noted. "The current agreement includes no enforcement mechanisms, and no conditions to the federal money. Why should provinces pay any more attention to the guidelines than they have previously?"

Equally serious is the governments' silence regarding increasing private pay, and for-profit delivery. The federal government has not been enforcing the Canada Health Act, resulting in the increasing proliferation of private, pay-as-you go imaging and surgical facilities that allow patients who can pay to jump the queue.

"Where is the federal will to ensure national standards of universal access?" Dr. Dhalla asked. "With not a word from the federal government about maintaining equal health care irrespective of ability to pay, the deal does nothing to halt creeping privatization."

"Roy Romanow's report said that federal money must be used to buy change," Dr. Guyatt concluded. This deal represents another federal give-away, with minimal progress toward serious health care reform." ♦

Released September 17, 2004 by the Medical Reform Group.

A NEW LIBERAL VERSION OF PRIMARY HEALTH CARE

Rosana Pellizzari

Primary care reform, according to Liberal Party election promises, is being unrolled across the province, despite a paucity of details. The Tories brought us Family Health Networks (FHNs) and then Family Health Groups (FHGs), and soon we will see FHTs (Family Health Teams) sprouting up across the healthcare landscape. In fact, our new government would like to see 45 new FHTs announced before the ends of the 2004 fiscal year, March 31, 2005.

Although specifics are lacking, Dr Jim MacLean and his team are taking that message out to communities throughout the province in organized public sessions scheduled this month. With such a tight deadline, the province is keen to negotiate contracts with any interested parties, including existing Family Physicians' practices with FHN or FHG contracts in place.

A major difference between the new FHT and the recently launched FHG/FHN models is the possibility of community or non-physician governance. The only other pri-

mary care models in Ontario with community governance are the Community Health Centres (including Aboriginal Health Access Centres) or the Community-sponsored "Group Health" in Sault Ste Marie. This means that other health professionals, or community partnerships, can submit for FHT funding. The only non-negotiable criteria for funding are that the population served must support at least one to two full time physicians.

How will the proposed FHTs differ from the existing menu of primary care delivery models? Again, details are sparse, but it appears certain that FHTs will not be as comprehensive as their cousins, the CHCs. Their scope will be health care, and not community development or advocacy. They will have to roster patients, and are being billed as having the flexibility to support both urban and rural, or remote, populations. They will receive funding for infrastructure and information technology.

The failure of the Ontario Medical Association-Ministry of Health and Long Term Care contract and the im-

plication for primary care reform was a sensitive issue at the public session hosted by the Ministry and which I attended in Kitchener recently. The crowd contained mostly physicians who were genuinely interested in moving forward and acquiring more resources, such as nurses, Nurse Practitioners and pharmacists to facilitate the delivery of interdisciplinary care. Funding for FHTs is probably, for the most part, federal, as part of the post-Romanow investment in primary care reform. The Association of Ontario Health Centres believes the FHTs may be an opportunity for the large number of groups who have been lobbying unsuccessfully for CHC funding to at least get a scaled down version of alternatively funded and delivered health care.

Deadlines for submissions are mid-February. We're off to the races on this initiative: it will be interesting to see both what the pick-up is, and what the final product will look like. ♦

RECRUITMENT CALL—SEXUAL AND REPRODUCTIVE HEALTH

Over the past year or so, we have attracted a number of new members, many of whom have joined the steering committee. Many have enriched the steering committee discussion, and a few of us have talked about the possibility of taking advantage of this new energy to review some issues on which the Medical Reform Group has been active in the past, with a view to updating where necessary, and educating all of our number on some of the most persistent. Our hope in launching a couple of working groups

in the new years is that some smaller working groups or committees can begin this process in a less formal setting, possibly in consultation with some of our associate members with legal and other expertise, then bring some of the results of their work to larger educational sessions as appropriate.

Rosana Pellizzari's recent work on sexual and reproductive health in Costa Rica is one example of an area where much work remains to be done. While the re-election of Bush in the US has given some of us cause for concern, and this will certainly continue to cloud the inter-

national picture on sexual and reproductive health, there are some small windows of opportunity.

This is a call for expressions of interest to review our existing policy on sexual and reproductive health. The group would likely work with long-time members Rosana Pellizzari and Catherine Oliver, and involve two to three face to face or electronic meetings in 2005. If you are interested in getting involved, contact medicalreform@sympatico.ca; leave a phone message at (416) 787-5246; or write the Medical Reform Group at Box 40074, Toronto M6B 4K4. ♦

STEERING COMMITTEE 2004-05

In response to members asking who is on the current steering committee, here are short biographies of several of our more active members. If you have an interest in joining the steering committee or a working group described in the newsletter, or want to bring an issue to the attention of the Steering Committee, please contact our Administrator at medicalreform@sympatico.ca.

Ahmed Bayoumi

Ahmed Bayoumi is a general internist and health services researcher in Toronto. His clinical and research interests focus on the health of people living with HIV and other disadvantaged populations. He is committed to the concepts of social and economic justice, which he views as incompatible with capitalism.

Irfan Dhalla

Irfan Dhalla is an internal medicine resident physician at St. Michael's Hospital and the Sunnybrook and Women's College Health Science Centre in Toronto. He graduated as the valedictorian of his University of Toronto medical school class in 2003. As a medical student, he and several of his classmates conducted a nationwide survey of medical students—their findings, published in the Canadian Medical Association Journal, showed that medical students overwhelmingly came from privileged families and that increasing tuition fees were adversely affecting the medical school population.

Since graduating from medical school, Dr. Dhalla has served as an editorial and research associate to the National Advisory Committee on SARS and Public Health, published several articles on inappropriate prescribing in the elderly, and currently sits on the executive committee of the Professional Association of Internes and Residents of Ontario. He joined the Steering Committee in 2003.

PJ Devereaux

PJ. Devereaux obtained his BSc from Dalhousie University and an MD from McMaster University. After medical school he completed a residency in internal medicine at the University of Calgary and a residency in cardiology at Dalhousie University. He is currently undertaking a PhD in Health Research Methodology at McMaster University. He holds a Canadian Institutes of Health Senior Research Fellowship Award. Dr. Devereaux has undertaken research comparing health outcomes and payment for care in investor owned private for-profit and private not-for-profit health care delivery systems.

Mimi Divinsky

Mimi Divinsky is a family physician in downtown Toronto, a Fellow of the College of the Family Physicians of Canada and a lecturer in the Dept. of Family and Community Medicine at the U of Toronto. She was, until a recent illness, medical co-director of the Sexual Assault Care Centre at Women's College Hospital. Dr. Divinsky has been active in the Medical Reform Group since the group's inception, and has played an important role on the Steering Committee since 1985.

Gordon Guyatt

Gordon Guyatt is a Professor in the Departments of Clinical Epidemiology and Biostatistics and Medicine at McMaster University. He has made important contributions to clinical and

health care research, recognized by over 350 publications in peer-reviewed journals. His educational work includes seven years as Director of the Internal Medicine Residency Program. His work in dissemination of evidence-based decision-making was recognized by a McMaster University President's Award for Excellent in Resource Design in 1996.

Dr. Guyatt was instrumental in founding the Medical Reform Group in 1979 and has spent most of the subsequent two decades as a spokesperson for the group. He has contributed to the development of MRG policy, and in recent years has taken a major role in packaging and dissemination of MRG approaches to health issues.

Ted Haines

Ted Haines helps people and workplaces solve occupational health problems. While recognizing, imperfectly, the massive barriers posed particularly by powerful political and corporate forces, he doesn't see why Canadians shouldn't have a health care system that protects and cares for them, irrespective of means. That would be part of the society we want. He's a co-chair of the Hamilton Health Coalition and on the administrative committee of the Ontario Health Coalition. "If the artist sees nothing within him, then he should also refrain from painting what he sees before him."

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STEERING COMMITTEE 2004-05 (continued)

Brad MacIntosh

Brad MacIntosh is currently pursuing his doctorate in the Department of Medical Biophysics at the University of Toronto. His PhD thesis involves using Magnetic Resonance Imaging technology (MRI) to understand stroke recovery. Brad's interests in health advocacy and activism generally focus on how biotechnology affects health outcomes. In addition to his interest in diagnostic imaging, Brad has also been active in critical analysis of the pharmaceutical industry and relevant Canadian policies. He has presented work on prescription drugs to the Federal government and helped to formulate a national pharmacare strategy.

Recently, Brad and other students in health professions programs founded a Student Medical Reform Group (sMRG) chapter at the University of Toronto. As Co-Chair for the sMRG, Brad is enthusiastic to find new ways to improve and extend Canada's public and universal health care system among a future generation of health care researchers and professionals

Adam Newman

Adam Newman is a family physician in Kingston. He works at a Community Health Centre where he helped to develop Kingston's first integrated primary care nurse practitioner program. After spending two years as a staff physician in Sioux Lookout, working with First Nations people in remote and underserved communities, he has continued working with marginalized and poorly served pop-

ulations in Kingston. These include: the unemployed; those on social assistance; the disabled; intravenous drug users; and street youth.

He is also active in the areas of Family Planning and contraception. In all of these areas, he maintains an interest in advocating for patients whose health suffers due to social and economic inequality, and who are threatened by moves to limit universal access to high quality publicly supported health care.

Rosana Pellizzari

Dr Rosana Pellizzari is the Medical Officer of Health for Perth District Health Unit, located in Stratford, Ontario. Prior to specializing in Community Medicine, Dr Pellizzari worked as a Family Physician in Hamilton and Toronto. As a Community Health Centre physician, she specialized in the care of immigrant, refugee and HIV infected populations. She is past president of the Association of Ontario Health Centres and a former Chair of the City of York Board of Health.

Dr Pellizzari holds academic appointments at the University of Toronto and the University of Western Ontario. She has worked internationally and in First Nations communities in Canada. She has been a health columnist for the Toronto Star and co-hosted a daily TV health show. She is active in the Medical Reform Group of Ontario, and in the International Women's Health Committee of the Society of Obstetrics and Gynecology of Canada.

Aaron Rostas

Aaron Rostas is a second year medical student at the University of To-

ronto. After attending an MRG event in Toronto, Aaron along with several other students was inspired to start a student MRG chapter at U of T. Along with fellow steering committee member Brad MacIntosh, he currently co-chairs this student group. Previous involvement in organizations such as Amnesty International have helped foster his growing interest in social justice, particularly within the areas of health and human rights. Although still searching out his career path, Aaron hopes to continue to pursue these interests and become involved in health on a global level.

Yves Talbot

Yves Talbot is Associate Professor in the Department of Family and Community Medicine and Health Administration at the University of Toronto and Director of the International Programs in the department of Family and Community Medicine.

Since 1995, he has been involved in South America in programs of Capacity Building in Primary Care. The programs are aimed at training teams of professionals working in different cities of Brazil, Chile and Argentina. Dr Talbot has served on the Ontario (PECCAR) Committee for Primary Health Care Reform and has a particular interest in the role of primary care and questions of Equity. ♦

PREMIERS SHOULD NOT GIVE UP ON PHARMACARE

The Medical Reform Group today sent a letter to each of the provincial premiers asking them not to give up on a national pharmacare plan. The physician group believes that a national drug plan is both vital and affordable.

“Under Medicare, Canadians have access to doctors and hospitals but not medications,” said Dr. Irfan Dhalla, a spokesperson for the MRG. “This makes no sense. Many drugs are medically necessary, and these should be covered in a similar manner to physician and hospital services.”

The MRG believes that the provincial and federal governments should share the cost of a pharmacare program. The feds should offer enough money to cover 50 per cent of the costs. As with Medicare, a province would have to agree to certain conditions to claim its share of the

money. These conditions would be the same as those for Medicare:

1. **Comprehensiveness**—provinces would be required to make available all drugs on a national formulary deemed necessary for Canadians to access.
2. **Accessibility**—provinces would be required to provide first-dollar coverage (i.e., patients would not have to pay a deductible or co-payment), initially for the most essential drugs and eventually for all drugs on the formulary.
3. **Universality**—All residents of the province should be eligible for coverage under uniform terms and conditions.
4. **Portability**—For travelling residents, coverage would extend to other jurisdictions.

5. **Public administration.**

“These five principles work for Medicare and they will work for pharmacare too,” said Dr. Rosana Pellizzari, Medical Officer of Health for the Perth District Health Unit and also spokesperson for the MRG. “Initially some provinces will be reluctant to join a national plan, but as with Medicare, eventually all will find the temptation of federal dollars impossible to resist.”

“Ralph Klein was right when he said the idea of a national pharmacare plan was a ‘stroke of brilliance,’” concluded Dr. Dhalla. “We call on him, his fellow premiers and Prime Minister Paul Martin to use this week’s First Ministers’ Meeting to make this brilliant idea a reality.”♦

Released September 13, 2004 by the Medical Reform Group.

HOW TO BUILD A NATIONAL PHARMACARE PROGRAM

Bradley Macintosh, an MRG Steering Committee member, prepared this draft discussion paper as a summary of MRG discussions to date on the value of continuing to press for a National Pharmacare Program, in anticipation of the November 4th, 2004 members’ meeting in Toronto. Given the complexity of the issues the Steering Committee will return to this issue in early 2005.

The introduction of a national universal pharmaceutical program, known as pharmacare, dates back to the 1964 Royal Commission on Health Services by Justice Emmett Hall (Canada, 1964). Nearly four decades later, in 1997 a National Forum called for a universal Pharmacare program, which the Liberal government endorsed at the time, but continues to evade. Recent events surrounding the First Ministers meeting in Sept 2004 have put the idea of pharmacare back on the radar, this time with a unanimous endorsement by Provincial and Territorial leaders.

The MRG has long since supported the idea of a national pharmacare program. The Canada Health Act (CHA) ensures that all Canadians have access to health services. However, the Act does not include pharmaceuticals as an integral component of the publicly funded health care system. This means that access to medications varies across socio-economic levels and across provincial and territorial jurisdictions.

Requirements for National Pharmacare

1. **Single payer**—A single drug purchaser affords bulk purchasing

power, which would result in decreased costs. This would particularly benefit small provinces and territories. The federal government is in a better position to control drug cost though monopsony buying power. Between 1987 and 2001, prescription drugs rose from 7 per cent to 12 per cent of total health care expenditures (Lexchin, 2003). According to a recent report, prescription drug spending is forecast to have reached \$14.6 billion in 2002 (CIHI 2003). In countries like Australia and New

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HOW TO BUILD A NATIONAL PHARMACARE PROGRAM (continued)

Zealand, where national pharmacare programs are in place, prescription drug expenditures are well below the Canadian numbers. For instance, compared to Australia, Canadian prices in 2000 for new innovative products were 9 per cent higher (AusInfo 2001). In New Zealand, the drug budget is managed by the Pharmaceutical Management Agency (PHARMAC). The use of a variety of measures including reference based pricing and tendering has allowed New Zealand to cut its projected drug bill by almost 50 per cent (Pharmac 2003).

2. **A national drug formulary**—An independent body of pharmaceutical and health policy experts would create a list of necessary drugs that all Canadians should have access to. This list would be kept current and adjusted based on the latest scientific evidence. Thus, annual revisions to the list would occur. A national formulary would encourage sensible, cost-effective and safe use of medicines.

3. **Reference based pricing**—Selecting the cheapest drug from a list of drugs that have identical therapeutic application is an effective means of

reducing costs. For example, this strategy allows the government to select a drug that has equivalent effectiveness but is not on patent and thus cheaper. A national reference based pricing would extend from the success observed in British Columbia.

4. **First dollar coverage**—Governments paying for the first dollar for every prescription ensures that all Canadians have access to drugs independent of socioeconomic status. Initially, it may be appropriate to introduce a maximum deductibles and co-payments. As cost containment strategies begin to take effect, the proportion of government coverage can be expanded without incurring significant additional costs.

5. **Public Administration**—A National Drug Agency, organized by the federal government, would consist of physicians, pharmacists and health policy experts, similar to New Zealand's PHARMAC.

Provinces like Saskatchewan and Manitoba have experimented with universal and income-based pharmacare, while Alberta has passed laws that facilitate generic drug competition. A comprehensive and national pharmacare

program would extend and invigorate the CHA. As more provinces sign on to a national program, the federal government will be in a position to encourage remaining provinces to follow suit, such as by withdrawing funding for violations of conditions. ♦

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EXPERTS DISCUSS NATIONAL PHARMACARE: REPORT OF FALL 2004 MEMBERS' MEETING

The members' meeting presented a panel discussion featuring Dr. Joel Lexchin, professor of health policy at York University and emergency physician at the University Health Network, and Armine Yalnizyan, consulting economist and community-based activist; she was the first recipient of the Atkinson Foundation Award for Economic Justice; she is a public commentator on public finance issues in general, and a specialist on issues of health care financing.

Armine Yalnizyan began her presentation to the meeting by observing that several groups have reviewed drug costs (1964—Hall Commission, 1987—National Forum

on Health, 2001—Romanow and Kirby). Each group has produced essentially the same result: -- because of the (rising) share of drug costs in the provision of health care in Canada, a

strategy needs to be found to fund drugs more comprehensively.

The most recent experience of the federal-provincial-territorial meeting
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EXPERTS DISCUSS NATIONAL PHARMACARE: REPORT OF FALL 2004 MEMBERS' MEETING (continued)

in September in which the provinces very directly brought this issue to the table marks yet another opportunity. Yalnizyan also noted a commitment at the 2000 federal-provincial-territorial agreement on health to move toward a Common Drug Review, which appears not to have moved significantly since then.

Although the provinces and territories have moved on to other issues, Yalnizyan is convinced that there is a receptiveness and more generally an interest at the policy level to deal with this, though not necessarily in the manner proposed by the premiers. She recommends we consider a strategy which keeps this issue on the agenda by working first on developing consensus with health care workers at the very local level, takes this to provincial parliaments and then to the federal level. She has offered to assist in development of campaign materials and advise on meeting strategies where appropriate.

According to Yalnizyan, drug costs are the single largest cost driver currently in 2003, they accounted for \$16 billion in expenditures in 2003, of which \$7.6 billion was spent in public programs (provincial and federal drug benefit plans. This figure has tripled since 1991.

In February 2003, the Federal-Provincial-Territorial Health Accord set aside \$1.6 billion in a 5 year fund to reform catastrophic drugs and primary care. Almost nothing has been done, except that Nova Scotia has raised co-payments and the government of British Columbia has largely abandoned reference-based drug pricing. The commitment on drugs was renewed in September 2004 with a commitment to collaborate on improving the drug purchasing process.

Beyond the purchasing process, and a discussion of prescribing practices, which was dealt with in more detail by Joel Lexchin, Armine reminded the audience of a number of other smaller

and larger tactics available which would have some effect on the gross cost of drugs. None of these are new, and have been dealt with in greater and less detail by recent task forces and commissions:

- ◆ Bulk buying: volume brings economies of scale—this is of particular interest to smaller provinces, as it could increase their clout in the market place
- ◆ Creation of a national formulary or streamlining of provincial formularies to get the most effective and cost-effective drugs easily available and limit or minimize administration costs which are currently reproduced in each province—can begin to approximate the single payer situation we have with physician care and hospital services
- ◆ Direct contracts with suppliers on new drugs would generally be worth the supplier's energy given the likely market to be accessed
- ◆ Improve patent legislation to reflect the real research and development costs of useful drugs.

As for strategy, Yalnizyan believes that an effort begun by physicians in Ontario and British Columbia could have great rewards. Ontario spends \$2 billion for an Ontario Drug Benefit Plan for seniors, disabled and long-term social assistance recipients, a situation which has significantly affected their ability to contain costs in this part of the health budget.

Yalnizyan believes the most efficient way to proceed is to have the federal government take responsibility for a national pharmacare program. They, not the provinces, can make the best deal for the country. In addition, because of their jurisdiction over patents, and which they have used successively to favour drug manufacturers rather than drug purchasers, they have actually ended up off-loading additional costs to the provinces who are the largest purchasers.

She also observes that in a staged implementation process [where, for example, access would be available first to certain categories of users or for specified categories of drugs], the potential of reinvesting savings realized from bulk purchase could support further enhancements or extensions of the program.

Yalnizyan noted that although private drug benefit providers have traditionally kept below the radar screen, many large employers are beginning to look for alternatives to annual increases in benefit plan costs. She thinks they can be persuaded to trade these employee benefits for higher taxes. A relatively coordinated switch to add the 'savings' from private benefit plans to the personal income tax could complete the picture without significant changes for the average taxpayer.

Yalnizyan added, Pharmacare is smart because it can restore fairness to our system at little or no cost to individuals. While the waiting list issue has temporarily knocked pharmacare off the media stage, she is eager to work with physician activists who she thinks can play a central role in restoring the issue to the attention it deserves. She notes that none of the federal-provincial-territorial meetings over the past 5 years have significantly spent what was committed to address any of the major Romanow issues—pharmacare, home care or primary care. Moreover with projected surpluses as far ahead as the eye can see, we should concentrate on making the general economic and practice arguments for a national program and leave the detailed financial strategy until we have recuperated the level of political interest of early September, secure in the knowledge that adequate funding can be found immediately to

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EXPERTS DISCUSS NATIONAL PHARMACARE: REPORT OF FALL 2004 MEMBERS' MEETING (continued)

make a significant difference. She believes this strategy needs to begin with provinces—BC and Ontario are key and currently closer than many others ideologically to making such a decision, and that a lobby at the provincial level in the next couple of months can renew the issue by federal budget time.

The second panelist, Joel Lexchin, addressed more of the clinical and practice issues relating to the current trend of escalating drug costs. His presentation began by focusing on addressing the reality of innovation in pharmaceuticals, citing a French review of 2,700 new preparations, among which the reviewers identified 7 products with genuinely innovative therapeutic uses.

He also noted that the process for drug approvals is not foolproof, given that initial testing tends to be based on relatively short term use. To support this point, he noted a report which found that of 548 new drugs introduced between

1975 and 1999, 117 subsequently had drug alerts posted or were completely withdrawn, when they were shown to have adverse effects.

Another issue, which appears to have inspired the Ontario Health Minister in his recent negotiations with the OMA, relates to prescribing practices of physicians. The literature is replete with examples of inappropriate prescribing, and Lexchin has great concerns that the heavy advertising of new drugs and the increase in direct to consumer advertising to which we are subjected adds to the potential for added risk to patients. He counselled prohibition of direct to consumer advertising (an MRG position for some years) and a system of controlled listing of new drugs for a period beyond the current drug approval limits. While this latter strategy is complicated in a multiple-payer system, it could also work in a single payer system, where a single database could monitor use and adverse effect patterns.

Lexchin also reported on his recent studies in Australia where he noted

that the national drug procurement program includes an expanded role for pharmacists and pressure for a shift in physician payment from fee for service. He thinks more education will be critical if the government is serious about changing prescribing patterns, although he noted that the Australian drug agency is set up as an independent agency and better accepted by physicians than one imagines a directly government-operated agency might be.

In the question period following the presentations, Yalnizyan recognized the central role of physicians in leading the charge among health care workers with a focus on appropriate prescribing. She indicated that more of the business sector—employers who provide benefit plans—are increasingly seeing the plans and the escalating costs of providing them a nuisance. Likely the only business sector to be averse to a more clear and accountable national role in drug procurement are pharmaceutical manufacturers. ♦

THE PHARMACEUTICAL BENEFITS SCHEME: A UNIVERSAL SCHEME

Medicare Fact Sheet 10 of The Doctors Reform Society of Australia, first published in winter 2001, and reproduced with permission.

The Australian Pharmaceutical Benefits Scheme (PBS) commenced over 50 years ago. At that time, there was concern that many people could not afford expensive but valuable new drugs such as penicillin. A Pharmaceutical Benefits Advisory Committee (PBAC) was set up; they recommended that a limited list of life saving or disease-preventing drugs should be made available on prescription free of charge, the costs to be paid for by the Federal Government. The World Health Organization subsequent-

ly endorsed this approach as a useful mechanism to ensure equity of access to necessary drugs.

Our PBS has evolved from a scheme that fully subsidised a small number of drugs to one that partially subsidises about 650. The cost of the PBS has escalated and patient co-payments, brand premiums and other strategies have been used to transfer some of the cost to consumers.

The PBS purchases about 90 per cent of all prescription medicines. This near monopoly power has resulted in Aus-

tralian drug prices being substantially lower than the OECD average while still retaining general access to a comprehensive range of medicines. This has been good for Australian consumers but it has attracted determined opposition from the international pharmaceutical industry.

Escalating PBS Costs

In 1948/1949 the PBS cost the Federal Government \$298,074. It took 40 years for the costs to reach a billion dollars but more recently costs have been rising far

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THE PHARMACEUTICAL BENEFITS SCHEME: A UNIVERSAL SCHEME (continued)

more rapidly. In 1999/2000 the PBS cost the government \$3.45 billion, an increase of 16 per cent on the previous year. The 2001 budget papers estimated PBS expenditure for 2000/01 to be \$4.26 billion, a 22 per cent increase on the previous year.

There are several reasons for escalating PBS costs. National campaigns have improved drug treatment of asthma, depression and elevated blood cholesterol levels. Hospitals have limited supplies of drugs to patients when discharged and have privatised outpatient clinics and pharmacies.

But the major cause of increased PBS costs has been the growth of new, more expensive medications. Their prescription has not always accorded with clinical best-practice guidelines. Many of the prescriptions written for these drugs are for uses that have not been approved by the PBAC as cost-effective. In many cases the PBS is paying a price for these expensive medications that is far higher than would be justified by the health benefit achieved.

One of the main drivers for increasing pharmaceutical costs is industry marketing. According to the industry's own figures, manufacturers spend up to one-third of sales revenue on marketing, twice as much as they spend on research. A clash occurred in 2000-2001 over direct-to-consumer advertising (DTCA) of prescription drugs. The Australian Pharmaceutical Manufacturers Association (APMA) is lobbying the Federal government to remove current restrictions on DTCA of prescription drugs. The U.S. experience shows why.

In 1999, U.S. pharmaceutical companies spent \$US 1.8 billion on DTCA. This was a 40 per cent increase over 1998. \$1.1 billion was spent on television ads, a 70 per cent increase over 1998. Forty one percent of DTCA spending was concentrated on ten products. The top-selling 25 DTCA drugs accounted for 40.7 per cent of the total increase in retail drug sales between 1998 and 1999 (i.e. \$7.7 billion of the \$17.7 billion increase). There was a 19 per cent increase in retail drug sales in

1999 compared to 1998. Doctors wrote 34.2 per cent more prescriptions in 1999 than in 1998 for the top 25 DTCA drugs. Doctors wrote only 5.1 per cent more prescriptions for all other prescription drugs.

Changes to the PBAC

Over the past few years, individual pharmaceutical companies have taken legal action over PBAC decisions to deny listing of drugs such as the erectile dysfunction treatment sildenafil (Viagra). They have successfully lobbied the Federal Health Minister to replace PBAC members judged antagonistic to pharmaceutical industry and have succeeded in getting a former industry lobbyist appointed to the committee.

Minister Wooldridge has argued that these changes to the PBAC have resulted in a better committee. Critics see this move as the latest pro-industry initiative of the Federal Government. They argue that adding a former industry lobbyist to the PBAC is akin to placing the defendant on the jury. They claim it is likely to inhibit free debate among independent experts and could result in more costly drugs (with more marginal benefits) being added to the PBS.

This, in turn, would lead to an even greater PBS cost blow-out that the government would inevitably pass on to consumers via higher co-payments, de-listing "less-essential" drugs and other strategies. The end result would be a U.S. style pharmaceutical system where poorer citizens could no longer afford necessary drugs.

Sustaining Equity and Access in the PBS

Over the last 10 years a variety of strategies have been employed in Australia to try to improve medicinal drug use.

The Pharmaceutical Health and Rational Use of Medicines (PHARM) Committee recommended a quality use of medicines (QUM) policy as the final integrating arm of national medicinal drug

policy. They advocated independent information; drug audits and targeted education aimed at both consumers and health providers. PHARM was successful both in gaining small amounts of funding for QUM projects and in proving that certain strategies worked.

Government then set up a National Prescribing Service (NPS) in addition to PHARM. The NPS works with Divisions of General Practice and has primarily focused on educating prescribers. For an expenditure of about \$5 million per annum they have demonstrated improvements in prescribing worth about \$15 million per annum. While NPS activities are undoubtedly worthy, the savings achieved represent less than 2 per cent of the \$800 million annual increase in the cost of the PBS.

The 2001 federal budget provided another 4 years funding for the NPS (at the same level) and also allocated \$14.6 million (over four years) for "a consumer education strategy". The challenge for government and opposition is to re-examine existing strategies and structures and formulate better ways of ensuring the sustainability of the PBS.

The Friends of Medicare Alliance believes such strategies should include removing the former industry lobbyist from the PBAC, more rigorous PBS price / volume negotiations, more independent information, audit and other decision support functions incorporated into prescribing software, less pharmaceutical promotion (especially resisting DTCA), and budget holding or other forms of clinical governance to encourage physicians to prescribe more cost-effectively.

We also believe that new structures are required and that PHARM, the NPS, the PBAC and related bodies should be rationalised and reorganised.

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INTRODUCING MEDICARE'S NEWEST CHILD: NATIONAL PHARMACARE

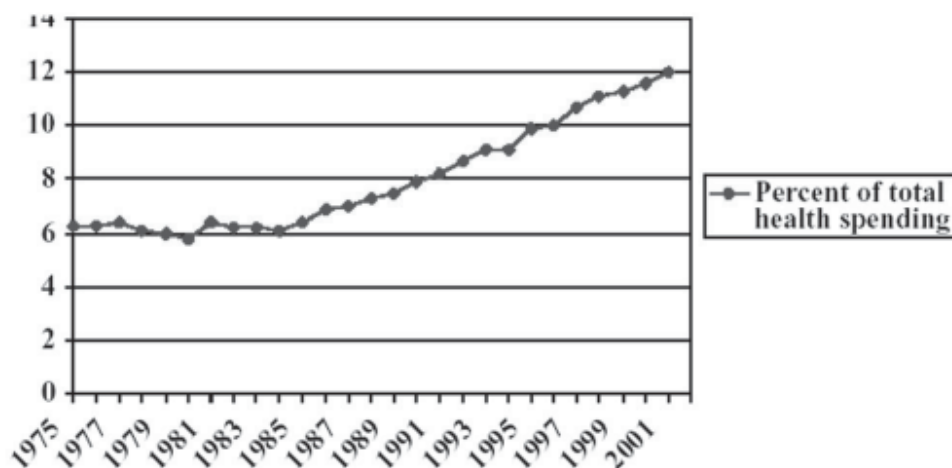
Brad MacIntosh

Prescription drugs continue to play a larger part of health care in Canada. Year after year, the number of prescriptions increase: in 2003 retail pharmacists dispensed over 350,000,000 prescriptions¹. Roy Romanow's reported the average Canadian has 10.1 prescriptions per year². This alarming number would lead you to believe that the average Canadian is able to afford their prescription drug costs. For the most part, this is true. Across Canada, drug coverage is a hodge-podge mixture between private and public plans.

Although comprehensive data is hard to come by, a pharmaceutical policy expert, Dr. Joel Lexchin explains in 1995, 88 per cent of Canadians had some sort of coverage: 62 per cent had private insurance, 19 per cent were covered under public provincial plans, and 7 per cent were covered by both private and public sources³. The 12 per cent of Canadians that have no drug coverage either do not fill prescriptions or incur out-of-pocket expenses.

Prescriptions drug costs make up a larger piece of the health care expenditure pie, not only because of the increased number of prescriptions, but also due to increased cost per drug. Newer drugs are more expensive, although they tend to be no more effective and less safe⁴. For example, the French drug bulletin, *Prescrire International*, has recently published summary statistics on almost 2500 new preparations or new indications for existing drugs that it evaluated between 1981 and 2001. In that time period it rated just 76 (3.0 per cent) as major or important therapeutic gains while close to 1600 were assessed as being superfluous because they did

Prescription Drug as a Percentage of Total Health Expenditures⁷



not add to the clinical uses offered by previously available products⁵.

Other countries, like Australia and New Zealand have been successful at containing costs. For example, the use of a variety of measures including reference based pricing and tendering has allowed New Zealand to cut its projected drug bill by almost 50 per cent⁶.

Based on these statistics it is reasonable to ask "do we need a new prescription drug plan in Canada?" Economist Armine Yalnizyan explains now is the time to expand coverage, to a more equitable and cost-effective system: "One way or another Canadians pay their own drug bills, whether through insurance, taxes or out-of-pocket"⁸. So is there a better way to pay for prescription drugs?

Pharmacare makes financial sense

1. *You are paying anyway* – Over the past decade, the breakdown in how drugs get paid for has been fairly consistent: In 2003, 47 per cent of the \$16 billion drug expenditures came from public dollars,

while private expenditures were 35 per cent by insurers and 18 per cent out-of-pocket expenses⁹.

2. *Cost Containment is possible* – Large provinces like Alberta and Ontario already reap the benefits of buying drugs in bulk, much like how Shoppers Drug Mart is able to "leverage its cost base and increase profitability"¹⁰. By extending bulk-purchasing to a national scale, smaller provinces would also enjoy benefit, resulting in reduced drug costs across Canada.
3. *Unequal out-of-pocket expenses* – A 1996 report documented a glaring disparity between low-income and high-income groups when it comes to out-of-pocket drugs expenses between 1964 and 1990. Low-income groups who do not qualify for welfare benefits, nor have a private insurance benefit program, pay seven times that of high-income groups, as a function of total family expenditures¹¹.

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MESSAGE TO PREMIERS ON THE EVE OF FEDERAL-PROVINCIAL-TERRITORIAL MEETINGS

On September 13, 2004, Steering Committee member Rosana Pellizzari sent a copy of the following letter of encouragement to Premier McGuinty and each of the provincial and territorial leaders.

I am writing on behalf of the Medical Reform Group of Ontario, an association of physicians and medical students in Ontario with a history of defending Medicare that now stretched back 25 years. On Tuesday, September 14th you and your provincial counterparts from across the country will have Pharmacare on your agenda. We believe, as you do, that a National Pharmacare program is vital if Canadians are to access the prescribed drugs that have become such an essential part of medical care. We applaud your recent effort, in Niagara on the Lake, to put Pharmacare on the agenda for your negotiations with our federal government.

In response to your advocacy, we offer, Premier, a caution, that a national drug program funded exclusively by the federal government carries excessive risks, including that of marginalizing Ottawa's role so that the future of our public health care system is put into jeopardy. Instead, we urge you to consider a cost-shared program in which the federal government will provide 50 per cent of the funding in return for provincial, and territorial, compliance with the following conditions:

- Universality
- First Dollar Coverage
- Portability
- Public Administration
- The establishment of and adherence to a National Formulary
- Uniform terms and conditions, such as Reference Based Pricing

Making Pharmacare a reality for all Canadians would be a truly significant and historic feat. It is within your grasp. On behalf of all the Canadian people, we wish you success in your meetings this week, and we look forward to all the ways in which you will make our health care system stronger, more effective, and sustainable. ♦

Rosana Pellizzari, MD, CCFP, MSc, FRCPC
Steering Committee Member

THREATS TO ACADEMIC FREEDOM SHOULD WORRY PUBLIC

The Medical Reform Group of Ontario today noted the serious implications of a Canadian Association of University Teachers (CAUT) task force report highlighting threats to academic freedom among clinical faculty in health sciences centres, and proposing solutions.

"When doctors exposing the dangers of drugs face intimidation and legal action, the public should be concerned," said MRG spokesperson Ahmed Bayoumi. "When doctors who highlight limitations in clinical care face loss of hospital privileges, the public must realize that patient care is threatened."

The CAUT report highlights the increasing threats to the academic freedom of doctors working in university settings. The case of Nancy Olivieri, who faced persecution not only from the drug industry but from the University of Toronto after she identified the dangers of a drug she was studying, is the most prominent. The report notes that the CAUT has received an increasing number of complaints from clinical faculty who face loss of jobs, income, or opportunities as a result of behaviour that institutions see as threatening to their interests.

"The report proposes much needed solutions to these growing problems," said another MRG spokesperson, Dr. PJ Devereaux. "Doctors who are threatened need arbitration procedures that protect them. They need backing and support when attacked by powerful institutions."

"The five academic physicians and scientists who authored this report are issuing a wake-up call," Dr. Bayoumi concluded. "When clinical faculty can't speak out on behalf of their patients, the public should be worried." ♦

Released November 18, 2004 by the Medical Reform Group.

MEDICARE CRITICISMS SIMPLISTIC

Smoking rates are much higher in France than Canada. The French have lower rates of coronary artery disease than Canadians. So, to cut coronary risk, Canadians should increase their smoking, right?

That's ridiculous, you say. Just because two countries differ on two attributes — smoking and coronary artery disease — doesn't mean that one causes the other. Unfortunately, participants in health-care debates sometimes rely excessively on simplistic cross-national comparisons.

Take a for-instance. The Fraser Institute, a right-wing think tank, points out that many countries allow user fees and private insurance for physician and hospital care. Some of these countries spend less on health care than Canada, while remaining competitive in health outcomes. Therefore, they argue, if we abandoned the Canada Health Act and allowed user charges for medically necessary physician and hospital services, our performance would improve.

But just as we don't know whether France's lower coronary risk happens because of, or in spite of smoking, we can't be sure whether our health-care problems are because of the Canada Health Act, or despite it. A more sophisticated analysis can help.

First, let's get the question straight: What is the best way of funding our health care? Through the public purse, from taxes; or privately, through insurance companies and out-of-pocket expenditures?

Next, we need to widen our scope beyond physician and hospital services, and consider all health services. In areas such as drugs, home care and eye care, Canada relies more on private funding than do most industrialized countries. The result is that 71 per cent of Canada's health-care fund-

ing is public, the rest private. Among 30 industrialized countries, 18 have higher proportions of public versus private funding—that is, public funds pay for over 71 per cent of expenditures. All but one of these 18 countries spends less of their GDP on health than Canada. So perhaps we could get more efficient by increasing, rather than decreasing, our ratio of public to private expenditures.

The next step in a more sophisticated analysis is to consider the entire spectrum of industrialized countries. The latest international figures show that a cluster of 12 countries spend between 8.6 and 11.1 per cent of their GDP on health. Canada is in the middle of this pack, at 9.7 per cent. The United States, at 13.9 per cent, spends far more than any other country.

Americans have a lower life expectancy than Canadians, a higher infant mortality rate, and worse outcomes in a wide variety of specific health problems, from asthma to hepatitis. Their higher expenditures don't translate into better health.

What distinguishes the U.S. system from the others? The U.S. has by far the lowest proportion of publicly funded health care, only 44 per cent. If private pay were a good thing, why is the American performance so disastrous?

Because there is so much variability in health systems, and in determinants of health, we still need to move beyond between-country comparisons of overall costs and overall health.

One additional source of evidence is a within-country comparison examining different aspects of Canadian health care. In the last decade, costs of the publicly funded parts of the Canadian system — physician and hospital services — have remained stable. Costs in the privately funded areas, particular pharmaceuticals, have exploded. These results suggest that when governments fund services, they have the motivation,

and the means, to control spending. Perhaps the most informative comparison is to look more closely at how private and publicly funded systems actually work. Because getting seriously ill involves gigantic costs, private insurance immediately springs up in user-pay systems.

Private insurance companies must develop insurance packages, market those policies against the competition, explain the policies to potential users, evaluate applications for insurance, assess claims, and still satisfy their investors with profits in the order of 10 per cent.

Public health-care plans, like our medicare, bear none of these costs. This explains why private insurers, which dominate the U.S. system, have overhead costs averaging 11.7 per cent. That compares to 3.6 per cent for U.S. Medicare, and 1.3 per cent for provincial health plans in Canada. It explains why the U.S. spends 31 per cent of its health-care dollars on administration, while Canada spends only 17 per cent.

When the National Health Forum of 1997, the Kirby Senate report, and the Romanow Commission studied our system carefully, they each recommended enlarging the scope of publicly funded health care. That's because a dispassionate look at the evidence that avoids simplistic cross-national comparisons shows that public payment — whether for physician and hospital services, for drugs, or for home care — provides better value for money. ♦

First published October 4, 2004, as one of Dr. Gordon Guyatt's monthly columns in the Winnipeg Free Press

HMOs DRIVE UP U.S. HEALTH COSTS

American lawmakers have recently been outraged to find that recruiting large corporations to deliver publicly funded health services to the elderly has substantially increased costs.

They shouldn't have been surprised.

Medicare is the name of the US health care program for seniors. It operates very similarly to our Medicare, paying health-care providers for delivering services to the program's beneficiaries. Also similar to Canada, those providers have until recently been hospitals and small groups of physicians receiving fee-for-service payments.

But recent changes in Medicare have opened the market to large investor-owned private for-profit Health Maintenance Organizations (HMOs) that have gained about 10% of the market. Their promise was the same one we often hear from advocates of private for-profit care in Canada: better service for lower cost.

Unfortunately, that's not the way it worked out. The Medicare Payment Advisory Commission, an independent federal panel, has informed congress that the companies are costing the system an average of 7 per cent more than the existing system. That would add up to \$50 billion of extra payments over the next 10 years.

The American experience illustrates the importance of getting beyond knee-jerk reactions to private health care delivery, and asking "what kind of private"? Your family doctor, and any specialists you need to visit, probably work in a practice setting with a few other doctors. These practices are usually "private" and some might characterize them as "for-profit". Certainly, the doctors need to pay their own salaries, and those of their administrative and nursing staff. The physicians, however, are in control of the practice decisions and have direct relationships with their patients.

When practices are investor-owned, the dynamic changes. Managers of health care corporations are responsible to the investors, not the patients. Their first responsibility is to deliver a profit margin, typically about 10 per cent.

In health care, for-profit firms also have much higher administrative costs than centrally administered public programs. For instance, American HMO Medicare companies have 15 per cent overhead, in comparison to 3 per cent in traditional fee-for-service Medicare. The investor-owned firms' have a final additional burden. Their executive salaries and bonuses are approximately 10 fold higher than the not-for-profit health care organizations. Independent physician practices needn't worry at all about paying executives.

No wonder corporate health care delivery costs more.

These latest developments in the US are consistent with a series of studies produced by our research team at McMaster University. The first two studies showed higher death rates in investor-owned private for-profit hospitals compared to private not-for-profit hospitals, and in outpatient for-profit dialysis clinics compared to not-for-profit clinics. The results of a third study, published this summer, showed that health care costs payers 19 per cent more at for-profit versus not-for-profit hospitals.

These results come from the U.S., but are likely applicable to the Canadian scene. Investigators conducted the original studies over a period of more than 20 years in which the U.S. health care system changed radically. The consistency of the findings suggests that they apply to a wide variety of administrative and reimbursement structures. Many of the studies focus on publicly funded programs. In this way, they mimic the Canadian situation: our choice is whether to invest our public dollars in for-profit or not-for-profit delivery. Finally, the same large corporations that were studied in

the U.S. will be moving into Canada if we expand for-profit health care.

Roy Romanow, whose Commission report remains the most authoritative overview of the Canadian health care system, has endorsed the McMaster findings. Since he released his report in November 2002, Romanow has continued to criss-cross the country seeking evidence that investor-owned for-profit delivery is less costly, or delivers better care. He keeps coming up empty, and his worries about for-profit delivery continue to grow.

Indeed, when examined critically, Canadian experiments with for-profit care have not brought good news. A for-profit clinic for cancer radiation therapy cost \$500 more per patient than the not-for-profit alternative. Winnipeg's Pan Am sports medicine clinic reduced costs when it moved from for-profit to not-for-profit status.

While we still have relatively little investor-owned private for-profit care, the sector is growing. It includes nursing homes and, in some provinces, home care companies, for-profit MRI facilities, and surgical facilities. Governments in several provinces are enthusiastic about expanding investor-owned for-profit delivery.

Will we continue with this foolish experiment until we face the American lawmakers' situation: a Canada-based study telling us that investor-owned for-profit health care costs more and delivers less? And then face the enormously challenges of moving back to not-for-profit delivery. Hopefully, we will choose to avoid the waste, and poorer health outcomes, of investor-owned for-profit care. ♦

First published November 2, 2004 as one of Dr. Gordon Guyatt's regular columns in the Winnipeg Free Press.

HEALTH CARE CRISIS IN NIGERIA

Anthony Okwuosah

The health care crisis in Nigeria is aptly captured by the medical advisory on the US embassy web site. It states, inter alia, that “the quality of government medical facilities is unacceptable by US standards”. It also further states that the quality of healthcare providers ranges from poor to fair and that most physicians and nurses do not meet US standards of training. The blood supply is not safe and blood-banking services are unacceptable. National Disaster management is not effective or functional.

As damning as these statements are, they are in reality understating the rot in the Nigerian healthcare system. The health indicators show a life expectancy at birth of less than 50 years and the probability of a Nigerian born child dying before age 5 is 182 per 1000 live births. Nigeria's total health expenditure as a percentage of GDP has been consistently under 4 per cent. Immunization coverage remains low with DPT3 for 2003 at 25 per cent as accessed from the WHO website on August 20th, 2004.

Tertiary hospitals are a shadow of their former glory with decayed infrastructure while primary health care units are overgrown with weeds and overrun by rodents and snakes with staff doing other business and showing up at month end for wages when available. The Pentecostal and Sabbath churches are convincing the people that the causes of high rates of mortality and morbidity are demons, ancestral spirits, poisons, curses and other supernatural sources. Our people from Aso Rock down to the shanties of Badia are becoming more superstitious, resorting to prayers while non-praying Europe and the US continue to enjoy better health care and prosperity.

Brain drain remains a very big problem with many of our best brains frustrated out of the country. Nigeria is estimated to have about 10 physicians per 100,000 population while Canada and the US have 229 and 250 respectively.

HIV/AIDS continues to be a problem and NACA (National Action Committee on AIDS), NASCAP (National AIDS/STD Control Program) and their international partners continue to advocate abstinence and safe sex as panacea to the near exclusion of improving the safety of our health care, especially medical injections and blood transfusion services. The immunization services should be commended for their efforts at making immunization injections safe. Also to be commended are the untiring efforts of NAFDAC (National Agency for Food and Drug Administration and Control) in controlling the undying scourge of fake and adulterated drugs.

The international covenant on Economic, Social and Cultural rights (ICESCR) prescribes the right to the highest obtainable level of health for all. It specifically requires States to take steps necessary for “the prevention, treatment and control of epidemic, occupational and other diseases.” The Committee of ECOSOC (Economic, Social and Cultural Rights) charged with monitoring adherence to ICESCR in 2000 in its General Comment 14 explains that the right to health at all levels consists of these interrelated and essential elements: appropriateness (cultural, social, and scientific), high quality, and acceptability. It does not insist on uniform standards for all societies but aims at the highest level attainable for each society. Nigeria, the self-styled “Giant of Africa”, should then aspire to be the giant in health in Africa at the very least. However, the reality is that the generality of Nigerians

are served one of the worst health dishes available on the planet earth. Every segment of Nigerian society shares culpability for this sad state of our health care.

The government, of course, bears the greatest responsibility for this state of affairs by chronically under funding the health care sector, appointing wrong leaders for the sector, implementing conflicting policies, programmes and guidelines, and fueling corruption. Corruption is not exclusive to the government; rather it pervades the whole system from top to bottom, employers to employees, care providers to the general public and the Nigerian society at large. The government has also woefully failed in the duty of setting standards and regulating practice.

The next culpable group are health care workers themselves who spend valuable energy, resources and time in internecine squabbles on leadership of the sector. In the private sector, the cadres abandon their roles and rather devote themselves to providing services they are not trained to provide. The doctors fail to collect consultation fees but instead vend medications to patients with the attendant conflicts of interest. They dispense medications available in their stocks or ones that are most likely to give them the greatest financial reward. Pharmacists, nurses and laboratory scientists are all consulting, diagnosing and prescribing, without adequate training.

Half-illiterate business men in Idumota, Mushin, Onistha Bridgehead, Aba and Kano, without the education and ethical indoctrination of our pharmacists, have taken over the importation of medications and sundry health supplies resulting in the flooding of our system with fake and adulterated products. The pharmacist also contends with the scourge of the patent medicine vendors, many of

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HEALTH CARE CRISIS IN NIGERIA (continued)

whom are called “doctors” by their patrons. It is common to see even well-educated persons walk into a patent medicine store, illegally stocked with ethical products and restricted medications, to consult a primary school drop out for medications to use for their ailments. The attendant, trained in the art of “mixing” by a master he previously served, dutifully doles out a variety of painkillers, anti-malarials, multivitamins and antibiotics to his patrons.

Laboratories are also busy churning out questionable results using questionable reagents and antiquated systems. Medications and reagents meant to be kept in well-regulated environments are left in unmonitored refrigerators to the vagaries of irregular power supply. Poor staffing is also a major problem in the private sector with the use of ill-trained auxiliaries and other attendants.

In the public sector with better staffing, poor work culture results in staff only putting in a fraction of the time they are supposed to and only half-heartedly rendering the service when they do. Laboratory tests of doubtful benefit such as Widal reactions are commonly used. Injections are overused and basic precautions to make them safe for the patient, the health worker and the community are not taken. Blood transfusions are being given with dubious, if any, screening due to near inexistent regulation and enforcement of existing legislation.

Nigerian society is also to blame. Our people are busy looking for guaranteed cures which modern medicine fails to give. A plethora of alternative Practitioners and healing ministries happily guarantee our ever so gullible people with miracle cures. The average Nigerian differs from his western counterpart in a very simple way. The westerner fixes his broken door, paints his house, and does most minor repairs on his appliances but goes to see a doctor when he is ill. The Nigerian calls an elec-

trician to change his bulb, carpenter to fix his door, painter to paint his child's room but when ill, he treats himself. He becomes the expert who decides on the test to carry out (typically, the Widal reaction and tests for the malaria parasite) and goes ahead to prescribe medications for himself.

International NGOs contribute to this bad scenario by creating vertical programmes with skewed incentives, poorly articulated sustainability strategies and shoddy, unplanned and unannounced sudden exits. They reappear sooner than later with fresh programmes that have little or no connection to their previous programmes.

There is no magic bullet that can solve the Nigerian health sector. However, curbing and minimizing corruption is perhaps the most important step government can take to restore hope to our people.

Important also are increased and sustained funding and appointment of qualified and competent people to head our health and para-public institutions with clearly stated time frames and measurable targets expected of them. No excuse should be acceptable for failure to achieve the targets within the stated time lines. Policies and guidelines should be enunciated and widely disseminated up to provider levels. These regulations, policies and guidelines should be strictly enforced at both governmental and private sector levels.

National health insurance schemes should be accelerated and greater awareness created. The pitfalls of privately financed and operated health insurance, which is overused and abused, should be remedied.

Improvement in our economy and a reduction of the people's poverty level will, of course, positively affect our health. This will add an incentive to help

retain our doctors, nurses and other health care professionals in the country. ♦

Dr Anthony Okwuosah is director of the Medical Rehabilitation Centre for Trauma Victims, the Project of Rights Relief Rehabilitation Reconciliation Services, Lagos, Nigeria. Dr Okwuosah is participating in research on injection safety with Dr Bernadette Stringer, principal investigator, of the University of Western Ontario. Ted Haines, MRG steering committee member, is a co-investigator.

AUSTRALIAN PBS (continued)

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Supporting references, links to policy documents, PBS statistics, media debates and related sites such as QUM and the NPS can be found at www.phaa.net.au ♦

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INTRODUCING MEDICARE'S NEWEST CHILD (continued)

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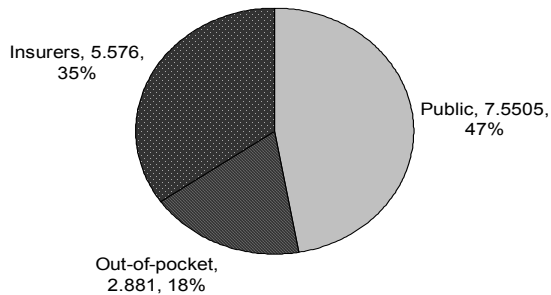
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INTRODUCING MEDICARE'S NEWEST CHILD: NATIONAL PHARMACARE (continued)

**Canadian Public & Private Drug Expenditures
in \$ billions: 2003 (CIHI report)**



Pharmacare would improve health outcomes

1. Creating a National Drug Formulary

– A national body that selects drugs that are available to all Canadians ensures safety and cost-effectiveness of commonly prescribed drugs.

2. National monitoring–Pooling databases from across provinces and territories to a centralized location would minimize the risk of adverse drug reactions, since larger sample sizes are more sensitive to side-effects. Monitoring at a national level would also provide demographics on under/over-use of certain drugs.

3. Improving prescribing patterns – A national body would be more effective at instituting mechanisms to improve health outcomes. A national body could create incentives to improve prescribing patterns by doctors, or contract pharmacist to act as consultants to advise patients in a community oriented setting are two good examples. ♦

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