

Medical Reform

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HEALTH REFORM CANADA AND US: WHAT DOES THE EVIDENCE TELL US?

Gordon Guyatt

Ambrose Bierce defined politics as the conduct of public affairs for private advantage. Never has this definition seemed more appropriate than in the conduct of the debate regarding reform of the American health care system proposed by U.S. president Barack Obama.

That the debate has been characterized by misinformation, distortions - and, many would say, outright lies - is beyond dispute. One category of misinformation relates to the presentation of the state of the Canadian health care system. Canadian health care has been characterized as leading to catastrophic delays in the delivery of critical health care interventions. Such delays, it is implied or openly contended, would become routine in the United States, even among the well insured, with the implementation of the Obama initiatives.

In a world in which evidence had a place in this particular health policy debate, where would one look to test these assertions, and examine the relative impact of Canadian versus American health care? One option would be to look at the health status of the population of the two countries. In doing so, one would find that Canadians live longer than

Americans, and that in various other indices of population health (such as infant mortality) Canadians do better.

One might legitimately argue that such statistics have only indirect, and perhaps little bearing on the state of the American and Canadian health care systems. After all, health care is only one, and not the most important, determinant of health. The different demographics of the two populations, the extent of poverty, the use of firearms, and varying personal habits may all be far more responsible for Canadians' superior health status than differences in the delivery of health care.

Indeed, despite these statistics, it may still be that American health

care is superior to the Canadian variety. The fact that Americans spend almost two dollars on health care for every one that Canadians spend suggests that this is indeed likely to be the case. After all, Americans must be getting some benefit from all those extra dollars - that is, billions of dollars.

So, if population health status provides only very low quality evidence regarding the relative merit of health care systems, where might one find higher quality evidence? In a world very different from the one we live in, one could randomize - that is, decide by a procedure analogous to a coin flip - people experiencing the onset of serious illness to receive their subsequent health care in Canada or the United States. Such an experiment would provide the highest quality evidence on the effectiveness of the two health care systems. We must, however, look to realistic studies that would come as close as possible to achieving the merits of a randomized trial: examine similar sick patients, presenting at the same stage of illness, in the two countries.

Observational studies of such populations will provide the highest quality evidence available. If one left it to the advocates of one system or

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Editorial committee this issue: Gordon Guyatt, Janet Maher

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

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

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

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

EDITORIAL NOTES

Janet Maher

This is a short newsletter, but despite appearances, there is a lot going on. I'll try and summarize some of the items on our current agenda.

On October 22nd, CMA President-elect Jeffrey Turnbull visited Toronto to make a very personal presentation on access and equity based on his practice in Canada and internationally.

As you will see from Ritika's report, he also made several suggestions about engaging the CMA on our issues, and an ad hoc work group is assembling briefing material on the issues we have advocated on for 30 years now, expecting to provide a first briefing before the end of the year.

Last issue, I noted that debate was underway on Ontario Bill 179, on expanding the scope of practice for several health care professions. This issue we have a very thoughtful piece from Dr. Alba DiCenso, a friend of the MRG, which provides great hope in comparison to the 'high octane' approach of the OMA family practice section. We need, of course, to continue to be vigilant on the implementing regulations of this important bill.

Earlier this month marked the first anniversary of the McGuinty government's 'Poverty Reduction Strategy.' The first annual report focused on progress achieved in drawing a loose consensus on objectives and the Poverty Reduction Act passed in the spring of 2009.

The provincial government also announced an expert panel charged with advising the government on the legislative and policy change necessary to move forward with poverty reduction. I, for one, hope they don't ignore a landmark piece of work produced now a generation ago when

the Liberal government of the day faced similar challenges. Under the leadership of Justice George Thomson, a task force commissioned and reviewed some dozen research reports, and made 269 recommendations, of which perhaps 20 have so far seen the light of day.

I think there may be room for some updating of the Thomson report, but the research is already done. A lot of the proposals made in 1988 will still stand the test of time. All we need to do is mobilize the public, rather than join the media frenzy which this week attended the release of the annual report of the provincial auditor general.

For anyone who missed the Auditor General's report, the focus was on an increase of \$67 million in spending on the Special Diet Allowance, a provision which has been used by some MRG members to attempt to address deficiencies in social assistance for their clients. This was part of a very much larger 'overspending of some \$1.2 billion. The majority of that money went not to recipients, but to government-preferred vendors of aids for persons with disabilities (wheelchairs, scooters, oxygen). Still those events are probably not unrelated to a recent decision of the College of Physicians and Surgeons of Ontario to file a complaint of unprofessional conduct against a Toronto physician..

Last, but not least, let me draw the attention of members to the Toronto Star oped of November 22, 2009 by Dr. Philip Berger, calling on the College to reconsider its 'heavy-handed' approach to methadone treatment in Ontario.

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HEALTH REFORM CANADA AND US (continued)

the other, they could easily cherry-pick studies that support their position. American health care advocates would find and highlight studies that suggested the superiority of American care; enthusiasts for the Canadian system would do the opposite.

The solution to this problem is to conduct what is called a systematic review: a literature review that builds in multiple strategies to reduce bias and arrive at an accurate representation of the highest quality evidence. Such strategies include explicit eligibility criteria, a comprehensive search, assessment of the validity (risk of bias) of the studies found, and duplicate evaluation of study eligibility and validity. Our research group at McMaster University, in collaboration with investigators in the United States, undertook such a systematic review addressing the outcomes of care in Canada and the U.S.

Our objective was to systematically review studies comparing health outcomes in the United States and Canada among patients treated for similar underlying medical conditions. To identify such studies, we searched multiple bibliographic databases and resources. Implementing a tedious and resource intensive procedure necessary to guard against bias in this highly political work, we masked study results before determining study eligibility - that is, those determining eligibility were unaware of the study results. We abstracted study characteristics, including evaluations of methodological quality (i.e., validity or risk of bias) and generalizability.

We identified 38 studies comparing populations of patients in Canada and the United States. Studies addressed diverse problems, including cancer, coronary artery

disease, chronic medical illnesses and surgical procedures. We identified two criteria that characterized the highest quality studies: first, the use of extensive statistical adjustment to deal with inevitable differences in the populations, and second the enrolment of broad populations (avoiding the problem of idiosyncratic health care settings). Of 10 studies that met these two key criteria, 5 favoured Canada, 2 favoured the United States, and 3 showed equivalent or mixed results.

Of 28 studies that failed one of these criteria, 9 favoured Canada, 3 favoured the United States, and 16 showed equivalent or mixed results. We were hoping to generate a meaningful pooled estimate that would indicate the overall impact of the two systems. We did conduct a pooled analysis for studies that reported the most important outcome, mortality. The pooled estimates favoured Canada (relative risk 0.95, 95% confidence interval 0.92–0.98, $p = 0.002$ suggesting a statistically significant 5% reduction in the relative risk of dying if one received care in Canada. The results, however, were very heterogeneous (that is, as listed above, some studies strongly favoured Canada, others the United States), and we failed to find convincing explanations for this heterogeneity. Thus, the pooled or overall estimate is of very limited value.

The only condition in which results consistently favoured one country was end-stage renal disease, in which Canadian patients fared better. A possible explanation for this finding rests in the fact that 75% of American dialysis facilities are for-profit institutions; there are very few such institutions in Canada. One of our previous systematic reviews dem-

onstrated, for dialysis facilities in the United States, a mortality reduction of approximately 10% for the not-for-profit versus the for-profit dialysis facilities.

The results of our systematic review show that available studies suggest that health outcomes may be superior in patients cared for in Canada versus the United States, but that differences are not consistent. The American debate has not neglected these findings completely. A high profile review from a group called the Urban Institute placed considerable emphasis on our work, and their report was highlighted in the *New York Times*. But like other sources of evidence, this rigorous evaluation has been a peripheral contributor to the battle, completely overshadowed by idiosyncratic case stories, rhetoric, and misrepresentation.

What is the explanation for the trivial role of evidence in the crucial decisions regarding the American health care system? Part of the explanation, I believe, lies in Ambrose Bierce's observation that I quoted at the beginning of this article. Approximately 5% of the U.S. GDP is now spent on health care administration (about a third of the 17% or so spent on health care in total). The insurance companies that consume a large part of this 5% are enormously powerful. Their interests coincide, to a considerable extent, with health care providers, particularly large for-profit providers, including the pharmaceutical industry. Through lavish donations to politicians and political parties, insurance companies and health care providers ensure that their interests are also the interests of the politicians in Washington.

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JEFF TURNBULL, MARGINALIZED POPULATIONS IN CANADA AND THE CMA BLUEPRINT FOR HEALTH CARE TRANSFORMATION

Ritika Goel

In collaboration with Students for Medicare and Canadian Doctors for Medicare's University of Toronto student chapter, this fall the MRG presented Dr. Jeffrey Turnbull, the new President-Elect of the Canadian Medical Association at or fall members' meeting.

He is certainly more than qualified to be in this position, being the Chief of Staff at the Ottawa Hospi-

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There is some comfort in knowing that the highest quality available evidence supports the positions we take regarding health care - our advocacy for public payment within a single payer system, and provision of not-for-profit care. The comfort is limited, however, when the evidence is largely ignored, and decisions are made in the interests of the few, and ignore the interests of the many. While the Medical Reform Group can do little about the sad evolution of the American health care battle, we can help ensure that the Canadian public, and Canadian decision makers, are aware of the evidence behind our advocacy of public payment and not-for-profit delivery of health care. To the extent we are successful, the contrasts between Canadian and American health care - in short, higher quality and more equitable care in Canada at more or less half the price - will continue. ♦

tal, former President of the CPSO as well as former President of the Medical Council of Canada, and a recipient of the Order of Canada for his work with the homeless in Ottawa. His candidacy for CMA President was greatly appreciated and welcomed by the Medical Reform Group, as he has clearly stated that he is a proponent of the publicly funded health care system and is a true advocate for marginalized populations in Canada and across the world.

Turnbull discussed his work in areas of the world such as Bangladesh, Nigeria and Kenya and compared his experiences and the needs abroad to those the marginalized homeless and native populations of Canada. The discussion focused on how issues such as HIV, hunger, and housing have parallels both in the developing world and among marginalized populations in Canada. Jeff has been the lead in designing the Ottawa Inner City Health Project of which he is the Medical Director—a program with a harm reduction model that has allowed for intensive care of the homeless population in Ottawa. Through services such as step-up and step-down units, palliative care, alcohol administration and more, this project has clearly demonstrated a sharp decrease in negative health outcomes, decreased emergency room visits and overall health care system cost savings.

The discussion started off as a little disheartening—looking at the intense disparity that exists in the health of marginalized populations

even in a developed nation that believes in equal access to health care such as Canada. However, it was also uplifting to hear about concrete solutions and positive outcomes coming out of an innovative idea. The audience felt empowered and genuinely engaged in the issues, and motivated to think more about potential solutions.

After discussing the health of vulnerable populations in Canada and around the world, we turned to a project currently underway in the Canadian Medical Association entitled the CMA Blueprint for Health Care Transformation. Jeff walked us through the proposed plan of the CMA for changes in our health care system which is focused around five main pillars:

1. Building a culture of patient-centred care
2. Incentives for enhancing access and improving quality of care
3. Enhancing patient access across the continuum of care
4. Helping providers help patients
5. Building accountability/responsibility at all levels

After his brief presentation, Jeff opened up the floor for discussion on ideas that the audience may have for interpretation of the CMA priorities. The discussion was candid and several people who spoke up were cautious as to the definitions of the some of the terms aforementioned such as “patient-centred care” or the negative aspects of providing incentives, and how these would be appropriately regulated. Jeff listened

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JEFF TURNBULL, MARGINALIZED POPULATIONS IN CANADA AND THE CMA BLUEPRINT (continued)

carefully to all of our comments and concerns, many of which he echoed and was quite positive in our ability as constituents of the CMA or even external parties to provide our views and be involved in shaping the course that this plan takes.

With such a positive outlook on the potential results of engaging with the CMA, the Medical Reform Group has decided to draft a document with our interpretation of some

of these pillars, how we feel concepts such as equal opportunity for health care, emphasis on the care of marginalized populations, the benefits of pharmacare and potential solutions in long term care can be incorporated into the CMA Blueprint. This will be developed over the coming weeks and we hope to be involved in discussion back and forth with the CMA and provide evidence for our assertions and recommendations.

Overall, the fall meeting was very well attended, well received and has left us with concrete action items to move forward with. We hope to continue to engage our future President of the CMA in issues pertaining to maintaining our public health care system, providing health for all, and ensuring an emphasis on the care of marginalized populations. ♦

MORE EVIDENCE HEALTH CARE EQUITY AND EFFICIENCY GO HAND IN HAND

A research study from St. Michael's Hospital in Toronto, released today, demonstrates how governments could extend the lives of patients after heart attack by free provision of five life-prolonging drugs. They could do so, lead author Irfan Dhalla and his colleagues show, at very little or perhaps no cost to the public.

Comparisons of American and Canadian health care show huge administrative savings from Canadian publicly funded and administered physician and hospital services. Additional savings flow from low-income individuals accessing preventative services in Canada that are unaffordable in the United States.

In Canada, efficient, equitable health delivery is restricted to physician and hospital services," said Medical Reform Group spokesperson Dr. Gordon Guyatt. For prescription drugs, we have an American-style two tier system. The result is not only administrative waste, but Canadians

who suffer medical complications and premature death because they can't afford needed medication.

Dr. Dhalla and colleagues studied what would happen if governments provided free to the public five drugs that rigorous research studies have shown reduce recurrent heart attacks and prolong life in patients who have suffered heart attacks. They found significant benefits in terms of both quantity and quality of life at minimal cost to the government. The reason is that these drugs, whose benefits are only seen over the long term, are associated with low adherence when patients have to pay out of pocket.

The study results show the benefits that Canadians could derive from a national Pharmacare program," said another MRG spokesperson, Dr. Ahmed Bayoumi. "At the very least, government programs should provide, free of charge, to all patients with chronic illnesses where specific drug treatments are known

to be both highly cost-effective and associated with poor adherence. There are many such conditions in addition to heart attacks — including, for example, diabetes. Governments need to take a broader, longer term view — and bring in a national Pharmacare program. ♦

Released November 30, 2009 by the Medical Reform Group

NURSE PRACTITIONER-PHYSICIAN COLLABORATION: A SOLUTION TO ACHIEVING HIGH QUALITY ACCESSIBLE PRIMARY HEALTH CARE IN CANADA

Alba DiCenso

In 2004, the Prime Minister and Premiers of Canada set the objective that 50% of Canadians would have 24/7 access to multidisciplinary teams by 2011. In a recent synthesis of the literature, Barrett and colleagues (2007) found that when compared to a uni-professional model of primary health care delivery, interprofessional collaboration models provide a broader range of services, more efficient resource utilization, better access to services, shorter wait times, better coordination of care, more comprehensive care, and better health outcomes for patients. Nurse practitioners (NPs) are increasingly becoming integral members of primary health care teams across the country.

Our research team has recently completed a decision support synthesis on advanced practice nursing in Canada that involved a literature review and stakeholder interviews (available at www.chsrf.ca in 2010). In this piece, I will draw from the synthesis to describe the factors that influence collaboration between NPs and physicians (MDs) in the delivery of primary health care in Canada.

Background

While they have worked in outpost settings in the Canadian North for more than 100 years, primary health care NPs (PHCNPs) were introduced in southern urban communities between mid-1960 and early 1970. Their integration failed for a variety of reasons including reduced MD income, lack of NP role

legislation for an extended scope of practice, inadequate support from policy makers and other health providers, and a perceived oversupply of MDs particularly in urban areas.

In the mid-1990s, numerous federal and provincial government reports, all calling for major primary health care reform (e.g., Romanow 2002), identified that the use of NPs could improve patient access to health services. Reform efforts were fueled by unprecedented federal and provincial investments in primary health care infrastructure and interdisciplinary health care teams. Government's interest in the PHCNP role revived; a second wave of role implementation was supported by legislation, regulation, remuneration mechanisms and funded education programs.

NPs are "registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice" (CNPI 2006: 4). All provinces and two territories currently have legislation in place for the NP role. Between 2003 and 2008, the number of licensed NPs increased from 656 to 2148, the majority of whom are PHCNPs working in Ontario.

PHCNPs typically work in community health centres (CHCs), family health teams (FHTs), home care agencies, and northern health centres with more recent involvement in emergency departments, long-term care settings and cancer

care prevention. Their main focus is health promotion, preventive care, diagnosis and treatment of acute minor illnesses and injuries, and monitoring and management of stable chronic diseases.

Recent Canadian studies have shown that primary health care models that include NPs result in improved chronic disease management (Russell et al. 2009) and improved accessibility, especially in underserved areas (CRaNHR 2006; Martin-Misener et al. 2009). According to a July 2009 Harris/Decima survey, the Canadian public is increasingly aware of and comfortable with NPs and many more citizens are willing to see an NP than have the opportunity to do so.

There are inter-jurisdictional variations in the scope of PHCNP practice. Some provinces have rigid prescribing legislation and regulation that restrict the PHCNP to prescribing from a specified list of drugs whereas other provinces use a less restrictive approach that relies on PHCNPs to assess their own competency to prescribe a particular drug. Because the list approach is cumbersome and cannot keep pace with innovations, some jurisdictions, including Nova Scotia and Newfoundland, have changed to a broader approach.

Last month (November 2009), Bill 179 was passed which will give NPs in Ontario open prescribing privileges and do away with laboratory and radiology lists by 2011. In some jurisdictions (including Ontario) higher rates of remuneration are paid to medical specialists for patient re-

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referrals made by an MD inhibiting PHCNPs from making referrals to specialists. In Ontario, the Public Hospitals Act does not allow an NP to admit or discharge.

The autonomous nature of PHCNP practice has created MD concerns related to liability as MDs have expressed confusion regarding their medico-legal responsibility when in practice with an NP, the adequacy of NP liability insurance coverage and vicarious liability. PHCNPs are, however, required to carry adequate liability coverage. Many receive this through the Canadian Nurses Protective Society (CNPS), which offers comprehensive protection including tail coverage. Two joint policy statements by the Canadian Nurses Association, the Canadian Medical Association and the Canadian Pharmacists Association and by the Canadian Medical Protective Association and the CNPS provide principles and criteria for defining scopes of practice and have alleviated many concerns around liability issues.

PHCNP-MD Collaboration

Collaboration between PHCNPs and MDs is influenced by factors that occur at two levels, at the front-line between PHCNPs and MDs working together to deliver patient care and at the level of organized medicine and nursing.

Working Relationship Between PHCNPs and MDs

Studies of collaboration have found that good PHCNP-MD relationships facilitate PHCNP role implementation; if not good, relationships become a significant barrier. Our MD interviews indicated that positive, respectful and trusting PHCNP-MD relationships along with

good communication and willingness to deal with conflict all contributed to PHCNP role integration. Nevertheless, many papers described MD resistance to the PHCNP role with reasons including liability concerns, scope of practice issues, lack of role clarity and concern about NP independent practice.

Funding arrangements that create financial competition and an employer-employee relationship between an MD and PHCNP impede collaboration. Time spent by non-salaried MDs consulting with PHCNPs should be compensated. Both the literature and interview participants indicated fee-for-service reimbursement impeded PHCNP integration when health care activities shifted to NPs resulted in loss of MD income. However, a number of regional health authorities in British Columbia and a number of underserved areas in Ontario have recently and successfully integrated NPs paid by the government into fee-for-service practices.

There is a recognized overlap in the scope of practice of PHCNPs and MDs and depending on how well this overlap is understood and managed it can be a source of tension. Many interview participants acknowledged that strong collaborative relationships were needed to negotiate shared areas of practice.

Specific skill sets are required to work collaboratively and suggestions to develop these skills include training and funding of team facilitators and interprofessional education. For example, in Ontario, the Quality Improvement and Innovation Partnership (QIPP) has been created to provide learning collaboratives for the primary health care sector to improve the effectiveness and efficiency

of interdisciplinary health care providers.

Organized Medicine and Nursing

Organizations such as the Ontario Medical Association (OMA) and the Registered Nurses' Association of Ontario (RNAO) are responsible for protecting the interests of their members. As a result, it is not surprising that the OMA would negotiate an incentive package that benefits MDs alone or oppose initiatives to facilitate full enactment of the PHCNP scope of practice (e.g., Bill 179 to give PHCNPs open prescribing privileges) or enable PHCNPs to improve patient access to care in communities with physician shortages.

More than ever a decision made between the government and one professional group will likely influence another. For example, the Ontario government negotiated an incentive program for physicians for preventative care. Under this compensation model, the work of the NP is included towards achieving targets for the incentive based activities.

The Nurse Practitioners' Association of Ontario (NPAO) (2008) notes that "in the spirit of team development, the notion that one provider is being paid an incentive for the work of others is incompatible and inconsistent with the interprofessional approach to care" (p. 2). Some practices have converted these into team-based rather than physician-specific incentives to acknowledge the contribution of the team to preventive care delivery.

Ontario's legislature recently held hearings on Bill 179, legislation that would allow pharmacists and NPs to provide an enhanced level of direct patient care, for example,

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through open prescribing. The OMA's family practice section launched what Tom Closson, President and CEO of the Ontario Hospital Association, described as a "high-octane advertising campaign claiming it [would] endanger the health and lives of Ontarians" (Toronto Star, October 6, 2009). Despite their strong opposition, Bill 179 was passed.

There are many communities in Ontario with a shortage of physicians and in response, the Ontario government has committed to create 26 NP-led clinics. NP-led clinics are a new model of care in which NPs work in collaboration with MDs and other members of an interdisciplinary team to provide comprehensive, accessible, coordinated family health care service to a defined population in areas where there are high numbers of patients who do not have a regular primary care provider. In addition to the provision of direct health care services, NP-led clinics focus on chronic disease management and disease prevention activities.

NP-led clinics, when compared to other primary health care delivery models such as CHCs and FHTs, have a lower ratio of MDs to NPs and MDs function in more of a consulting role. The key indicators for assessing the need for NP-led clinics in Local Health Integrated Networks (LHINs) include: the proportion of unattached patients, the prevalence of one or more of nine chronic diseases including diabetes, the number of FTE family physicians in a LHIN per 10,000 population, and the number of existing FHTs and CHCs.

The first NP-led clinic, situated in Sudbury Ontario, was approved and became operational in August

2007. Since then, 11 NP-led clinics have been approved; sites include Belle River, Sault Ste Marie, Barrie, Thunder Bay, Oshawa, Belleville, Essex, Glengarry South, Oro Station, French River and a second clinic in Thunder Bay to serve the Aboriginal population. Fourteen more are expected to be announced in 2010.

Although the consulting MDs and patients report high levels of satisfaction with the existing clinic, NP-led clinics have been strongly opposed by organized medicine. On November 19, 2008, the OMA issued a news release in reaction to the government's intention to expand NP-led clinics noting "Not only does this model [NP-led clinics] serve a small group of patients, but we have not seen any solid evidence proving its ability to provide high quality, cost-effective care... The OMA will continue to advocate strongly that every resident of Ontario deserves access to his or her own family physician."

Lague (2008) argues that NPs pose a threat to family physicians and that rather than providing "the support and reinforcement for which everyone hopes, they [NPs] will dispute and lay claim to the same areas of practice as family physicians... they are in direct competition for physicians' areas of expertise" (p. 1670). She notes that "eventually NPs will want to work as autonomous health care providers. This is already starting to happen; NP-run clinics are opening without physicians. This is the first step on a slippery slope at the bottom of which NPs become, essentially, substitutes for family physicians" (p. 1668).

Baerlocher and Detsky (2009) describe 'turf battles' between and within professions when they com-

pete to perform the same task. They explain that reliance on self-governing professional bodies to determine appropriate work boundaries is problematic as they may have no reason to cooperate with one another and that solving workforce problems this way requires successful negotiation that keeps the public's rather than the profession's interest in mind.

Tensions increase when words such as 'autonomous' and 'independent' are used to describe NP practice. As autonomous practitioners, NPs are licensed to practice in an expanded role and are liable for their own practice. NPs who function independently are those who set up their own practice and who work as 'solo' practitioners. While this model exists in the United States, it is rare in Canada.

The concern about NPs functioning 'independently' in NP-led clinics may have contributed to OMA's support of the introduction of physician assistants (PAs). For example, in a letter sent to family physicians in 2008, Dr. Jon Johnsen of the OMA Section of General and Family Practitioners suggested that PAs allowed for the preservation of the physician-patient relationship and provided true collaboration while NP collaboration with MDs was loosely defined and involved consultation rather than preserving the patient/MD relationship.

The title 'NP-led' may have been ill-conceived as it connotes independent NP practice rather than an interdisciplinary collaborative model. Another possibility is that the tension lies around who leads the team. Physicians are accustomed to being the team leads. As Hutchison (2008)

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notes: “the move toward collaborative and team-based approaches to care requires a culture shift that will be especially challenging for physicians who are accustomed to being the undisputed team leader. In an interdisciplinary environment, involvement of other professional and administrative staff in policy and management decisions is no longer discretionary” (pp. 13-14). While the NP-led clinic is interdisciplinary, it does challenge this traditional hierarchical relationship and may contribute to physician resistance.

While NPs and family physicians who work together ‘on the front line’ are positive about their collaborative relationship, much of the tension may be caused by a ‘staking of ground’ or ‘turf war’ between organized medicine and organized nursing. The NP-led clinic arose out of direct lobbying of the government by the RNAO and a group of local NPs in Sudbury and is the only organizational model that has been introduced in the last decade that has not been a product of negotiations between the OMA and the Ministry of Health and Long-Term Care (Hutchison 2009).

Health human resource issues, funding constraints, patient access challenges, increased emphasis on chronic disease management, primary health care reform, and an aging population have prompted significant transformations to the health care system. As a result most professions are having to adapt as boundaries between professional jurisdictions are continually renegotiated. Physicians feel threatened by NPs, NPs feel threatened by PAs, RNs feel threatened by Registered Practical Nurses (RPNs) and all struggle for clear iden-

tities (Beaulieu et al. 2008). This engenders understandable fears related to loss of autonomy and control and leads to resistance. At the front-line in primary health care, however, most physicians, NPs, health care team members, and patients report high levels of satisfaction with team-based care (Barrett et al. 2007). Almost 50% of fee-for-service physicians in Ontario have indicated an interest in working with NPs (DiCenso et al. 2003).

Hutchison (2009) has suggested that the government establish a mechanism to bring together both physician and non-physician primary health care providers to advise on primary health care policy development and implementation. He states “rather than dealing with policy makers through separate, private bilateral discussions, stakeholders would be obliged to hear each other’s perspectives and would be under pressure to serve the public good by constructively addressing areas of conflicting interest.” (p. 17).

If over the next few years, organized medicine and nursing are able to come to the table and collaborate in facilitating the delivery of high quality accessible primary health care, all Canadians will benefit. ♦

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CONFLICT OF INTEREST AT THE CIHR GOVERNING COUNCIL

The Steering Committee expressed its outrage at the appointment of a prominent drug executive to the governing council of the Canadian Institutes of Health Research, with a November 27, 2009 letter from Dr. Ahmed Bayoumi to federal Health Minister Leona Aglukkaq and members of the Commons Standing Committee on Health. One of the standing committee members, Dr. Carolyn Bennett responded almost immediately, and her letter follows.

We are writing today to call on you to withdraw the appointment of Dr. Bernard Prigent to the governing council of the Canadian Institute for Health Research (CIHR). The CIHR is Canada's public funder for health research. Its mandate is to fund research that improves the health of Canadians and builds a more effective and stronger health care system. We believe private health care industries have an irreconcilable conflict of interest with that mandate.

A drug company needs to return a profit to its shareholders. That objective puts the pharmaceutical industry in a position of choosing between promoting health or making money. The pharmaceutical industry has a disappointing record of putting profits before health, suppressing negative findings, under-reporting adverse events, ghostwriting articles to promote their products, and disguising drug promotion as research studies—all of which actively undermine the scientific process.

That is not a consideration that should be represented at the CIHR's governing council. The pharmaceutical industry should fund research that tests their products. But they should not have a place at CIHR's governing council where research priorities are established.

This appointment is directly contradictory to an international movement among health researchers and journal editors that is calling for greater transparency and avoiding conflicts of interest. Through their control of funding, the pharmaceutical industry is already a huge driver of the issues addressed by medical research in Canada.

The result is a relative neglect of research relevant to non-pharmaceutical interventions to improve health, health services research, and the exploration of determinants of health and illness. A voice for industry on the governing council of CIHR could only exacerbate this serious problem. Experts in health innovation and marketing with different interests, and without conflicts, are able to discuss how to make research results available for Canadians. They would be a much better choice for CIHR governing council than Dr. Prigent. ♦

DR. BENNETT RESPONDS TO PRESSURE ON THE COMMONS HEALTH COMMITTEE

At the time of my interview for the November 19 article titled "Federal Committee to review Pfizer v-p appointment to CIHR council," I had been surprised that 100% of the people I had spoken to at the CIHR Awards Ceremony that week were supportive of the appointment, including current members of the governing council.

Since my comments were reported, I have received a deluge of persuasive interventions opposing the appointment of Dr. Prigent. These comments have convinced me that the skill set to enhance the CIHR mandate of commercialization would be better met by the appointment of somebody who is not directly employed by the pharmaceutical industry.

Today, the Health Committee has agreed to hold an additional one hour meeting on December 7 to hear from representatives of the health law experts, ethicists and eminent researchers who are opposing this appointment.

I believe that the Governing Council of the CIHR would be better served by appointing an individual with the experience and expertise of translating health research into the market such as someone retired, working and/or teaching in the incubator environment such as MarS, but not someone currently on the payroll of the pharmaceutical industry.

I would also encourage your readers to read and consider the Petition Against the Appointment <http://www.gopetition.com/online/32371.html> which currently has over 2300 signatures. ♦

Dr. Carolyn Bennett, P.C., M.P., M.D.

AVOIDING ZERO: PUBLIC WEBSITE TO FOCUS ATTENTION ON HOSPITAL BUDGETS

Just as we were going to press, we got word from Rick Janson, Campaigns Office at the Ontario Public Service Employees Unions that they are opening an interactive public website, to encourage health care providers and the public to engage on the part of the provincial budget

which will affect hospital funding for the coming year.

We all understand the fiscal constraints of recession, but even the best scenario currently under discussion at the LHINs is basically status quo. All the while, equally under consideration are some \$5 billion in corporate and \$11-15 billion in personal

income tax cuts, and federal increases in funding, designed in the words of the federal minister to fix health care for a generation.

For more information and to get involved by sending messages to your elected representatives, go to www.avoidingzero.ca ♦

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
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- \$60 Intern / Resident / Retired / Part-time Organization
- Newsletter Subscriber
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Box 40074
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If you prefer, you may pay your membership fees and supporting contributions through our monthly payment option by completing the following authorization and enclosing a black cheque, marked "VOID" from your appropriate chequing account. I authorize my financial institution to make the following electronic payments directly from my account:
The amount of \$_____ on the first day of each month, beginning _____, 20____.
Please credit the payments to the Alterna Savings and Credit Union account (No. 1148590) of the Medical Reform Group. I understand that these electronic payments will continue until I give notice in writing to the Payee to stop doing so; that I must notify the Payee in writing of any changes to the information in the authorization; and that I must notify the Payee within 90 days of any error in the electronic payment.

Account holder's name (print)

Account holder's signature

Date

MRG CALLS FOR WITHDRAWAL OF PRIGENT APPOINTMENT

The Medical Reform Group today called upon Health Minister Leona Aglukkaq to withdraw the appointment of Dr. Bernard Prigent, vice-president and medical director of Pfizer Canada, to the governing council of the Canadian Institutes for Health Research (CIHR).

"The CIHR is Canada's public funder for health research," noted MRG spokesperson Dr. Ahmed Bayoumi. "Its mandate is to fund research that improves the health of Canadians and builds a more effective and stronger health care system."

Private health care industries have an irresolvable conflict of interest, noted another MRG spokesperson, Dr. Gordon Guyatt.

"A drug company needs to return a profit to its shareholders," said Guyatt. "Too often, that objective has placed the pharmaceutical industry in a position where they have to choose between promoting health

or making money. That's not a consideration that should be represented at the CIHR's governing council."

Bayoumi noted that the pharmaceutical industry has a disappointing record of putting profits before health. "Suppressing negative findings, under-reporting of adverse events, ghostwriting articles to promote their products, and disguising drug promotion as research studies are just some of the ways that the pharmaceutical industry has actively undermined the scientific process," he said. "New examples of disreputable behaviour on behalf of industry emerge on a regular basis."

"The pharmaceutical industry should fund research that tests their products," observed Guyatt. "But they should not have a place at CIHR's governing council where research priorities are established. This appointment is directly contradictory to an international movement among health researchers and journal editors

that is calling for greater transparency and avoiding conflicts of interest."

The pharmaceutical industry is already, through their control of funding, a huge driver of the issues addressed by medical research in Canada. The result is a relative neglect of research relevant to non-pharmaceutical interventions to improve health, health services research, and exploration of determinants of health and illness. A voice for industry on the governing council of CIHR could only exacerbate this serious problem.

"Experts in health innovation and marketing with different interests, and without conflicts, are able to discuss how to make research results available for Canadians," noted Bayoumi. "They would be a much better choice for CIHR governing council than Dr. Prigent." ♦

Released by the Medical Reform Group, November 27, 2009.

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