

Medical Reform

Newsletter of the Medical Reform Group

Issue 150

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Spring, 2010

ONTARIO'S BIG PHARMA DRUG WAR

Joel Lexchin

The Ontario government has recently announced major changes to the way that it will pay for generic drugs for those covered under its public drug plan, primarily people 65 and over and those on social welfare. The aim is to rein in rapidly increasing costs for the Ontario Drug Benefit Program. Up until recently spending has been going up by more than 10% annually and overall across Canada drug costs are the second most expensive part of the health care system behind only hospitals.

The current government made a first attempt to deal with drug spending back in 2006 when it reduced the price for generic medicines from 70% of the brand name drug to 50%. At that time, \$222-million in savings (from a drug bill of \$3.5-billion) from reduced generic prices and other reforms was predicted. There was never any independent analysis about whether those anticipated savings were realized. Now faced with a deficit of over \$20-billion and health care costs that take up 42 cents of every public dollar, the government is looking at a new initiative to rein in at least one segment of health care costs. The question of whether that 42-cent figure represents too much spending on health care or is mostly the product of a series of tax cuts that have reduced government revenue

is a crucial issue that must be taken up soon.

The Politics of Generic Drugs

One of the key factors that makes public drug plans affordable is the existence of generic versions for many of the products that are on the provincial formulary. Generic drugs work the same as the original brand-name products but are much lower in cost since generic companies don't incur the research and development expenditures and also don't engage in costly promotion of their products.

However, in order for generic drugs to get used they need to be dispensed by pharmacists and this gives

the pharmacy owners a huge stick in dealing with the generic companies. In effect what the pharmacy owners tell the generic companies is that they will not stock their products unless the companies sell to them at a discount.

The pharmacy owners are reimbursed by the government at the list price of the medication not the discounted price. Therefore, the discount goes to the pharmacy owners not the government. These discounts amount to about 20% of the price of the drug. What the government is now proposing to do is to eliminate these discounts, also referred to as professional allowances. Savings from making this change are projected by the government to amount to \$750-million annually which would be a substantial reduction in the annual \$4.14-billion that the government spends on prescription medications.

The pharmacy owners, primarily the large chains such as Shoppers Drug Mart and Rexall are vigorously protesting this move. Their claim is that these discounts are necessary to make their businesses economically viable and that without the discounts they will have to cut services, close stores earlier and/or start charging for services that have been provided for free up until now such as home delivery.

Few people seem to have much

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<i>Please visit our website at: http://www.medicalreformgroup.ca</i>	

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

Editorial work this issue: 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 issue, we have to thank Joel Lexchin for a quick and perceptive analysis of the Ontario government plan to begin its cost cutting by limiting payments for generic drugs in its drug coverage programs to rates closer to what prevails in the rest of the country. Also on the larger pharmacare issues, we have Irfan Dhalla's recent opinion piece published in the Toronto Star. Each points clearly to the position MRG has espoused and advocated since its inception.

Many were heartened by the election of Jeff Turnbull as CMA president last spring. As he takes office later this summer, we will be looking forward to the leadership on publicly funded health care that a national physicians' organization can give. In the meantime, we have been following with interest the CMA Blueprint and our briefing note *Building a Culture of Patient-Centred Care* is the first result of the steering committee's review and update of our policy to address some of the large questions in the blueprint document. We look forward to your comments and observations.

Our last issue gave rise to some pretty immediate membership feedback, as we reported on the CPSO complaint against Dr. Roland Wong on his alleged use of the Special Diet provision in provincial social assistance legislation. The issues are many and complex, and that case will wind its way through the disciplinary process for some time. The debate following the last newsletter, however, suggests there may be value in organizing an educational event for members on the issue in the near future—all the more critical as the Ontario Treasurer announced that the 2010 budget would

limit increases in welfare allowances to one per cent this year (previous Liberal budgets had allocated 2% increases) and that the McGuinty Liberals are determined to transform the Special Diet Allowance into food supplement to be administered by the Ministry of Health, apparently bypassing the special advisory committee it appointed at the end of 2009 and which has yet to report.

In the coming weeks, we can expect to hear much more about patient-focused funding, and you can look forward to some of that coverage in the next issue of MEDICAL REFORM.

Many will remember the very innovative conference hosted in March of 2009 by Students for Medicare, and supported with a special appeal from MRG members in memory of former steering committee member Mimi Divinsky. Please consider adding to your agenda their one day conference **Solutions from Within** we are co-sponsoring Saturday, May 15th at the University of Toronto Law Building.

For more information, e-mail medicalreform@sympatico.ca. ♦

Note: There will be NO Volume 29, no. 4. This issue follows Volume 29, no. 3 (issue 149).

ONTARIO'S BIG PHARMA DRUG WAR (continued)

sympathy for the large chains but the smaller independent stores are in a different situation. The large chains have become like supermarkets selling everything from books to telephones to cameras to groceries. Filling prescriptions is only a relatively small part of their business. However, typically the small independent stores focus on filling prescriptions and selling over-the-counter drugs and other drug related consumer products such as suntan lotion, toothpaste and the like. Losing the discounts could have serious consequences for them and for their patients especially if these stores are located in rural communities.

The government is not completely indifferent to what pharmacists are saying and has announced some relief for them. Dispensing fees for pharmacists in rural communities will go up \$3 and in urban centres they will go up \$1 amounting to about \$100-million in total. The message from the groups speaking on behalf of pharmacies is that this is too little.

The dispensing fee is the payment that the government makes for the advice that pharmacists provide for their patients. Up until now the government has largely frozen the dispensing fee at its current level of under \$7 for years. Dispensing fees for people paying out-of-pocket and for those with private drug insurance have not been regulated so by freezing public dispensing fees the government has in effect shifted that cost onto these two groups. This is especially troublesome for those without insurance who pay out-of-pocket since they tend to work at low wage non-unionized jobs and being at the lower end of the socioeconomic scale have more health problems and need more drugs. Freezing dispensing fees has also forced pharmacies owners to become more and more reliant on

the discounts that they receive from the generic companies, the very thing that the government is now complaining about.

The Way Forward: Alternatives Not Considered

Part of the solution is to stop paying pharmacists for being storekeepers and start paying them for the knowledge that they gained from going to university for four years. Pharmacists have been trained to know about drugs and government should pay them to monitor patients for adverse effects from medications, to go over the drug regimens that people are on, particularly people in high risk groups such as the elderly and children, to spend time discussing the harms and benefits of drugs that people are taking. As provinces reform primary care they should be looking to move many pharmacists out of stores altogether and putting them down the hall from doctors. When the doctors write a prescription people can easily go to a pharmacist who has the time to spend with them and the knowledge to properly advise them.

There is little doubt that generic drug prices in Canada are significantly higher than in many other countries and lowering these prices makes sense. However, if governments want to go where the savings really are then they need to start taking aggressive action on brand-name prices. The average cost of a generic prescription in 2008 was \$26 versus \$66.50 for a brand-name drug. Of the \$20-billion in revenue drug manufacturers receive, 70% goes to brand name drugs and only 30% to generic drugs. In 2007/08 two brand name drugs alone accounted for 10% of the total cost of Ontario's drug plan.

Before looking at how high prices might be tackled it is worth

briefly examining why prices are high in the first place. Drug companies claim that these prices are necessary so that they can recoup their investment in research and development and continue to develop new and better medications. At present the companies are touting a figure of at least \$1-billion (U.S.) as what is needed to bring a new drug to market. However this number is heavily contested since it relies on an analysis of confidential data from companies reported to a research centre that gets 40% of its income in the form of unrestricted grants from multinational drug companies. Moreover, the \$1-billion figure ignores the indirect subsidies that companies get through tax deductions on research spending. The only attempt to engage in an independent examination of industry information came during the 1970s and early 1980s when the General Accounting Office (GAO), the investigative arm of the U.S. Congress, sought financial data that would allow it to estimate research, development, marketing, promotion, and distribution costs for individual products. The drug companies objected on the grounds that the confidentiality of their cost and other data could not be protected. Ultimately the dispute went to the U.S. Supreme Court that ruled that the GAO was not authorized to collect this type of information.

On top of the question of how much money the industry spends on research and development is the actual value of the drugs that are marketed. Evidence from Canada and France indicates that at best about 15% of new drugs represent any significant therapeutic advantage over what already exists. While these drugs may be worth the prices that are being asked, the other 85% represent gravy

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ONTARIO'S BIG PHARMA DRUG WAR (continued)

for the industry and little to nothing for the public that takes them.

One way of bringing down prices is to use monopsony buying power, but right now Canada has 10 provincial, three territorial and four federal drug plans and no universal coverage. In contrast in Australia the national government covers all residents in the coverage. In contrast in Australia the national government covers all residents in the country for drug costs and is the only bargaining agent. As a result, brand name drug prices are about 9% lower in Australia than they are here. Having a single payer and extending public coverage to the entire population would put the government in a much stronger position vis-à-vis the drug companies.

One of the reasons why doctors switch from older, less expensive generic drugs to newer, more expensive but not necessarily any better or safer brand name drugs is the massive promotional campaigns that drug companies put on. In the year after the anti-inflammatory and analgesic Vioxx was launched Merck took out over 1000 pages of advertising in Canadian medical journals, company representatives paid 48,000 visits to the offices of Canadian doctors and left behind over 1,000,000 samples. (Less than five years later Vioxx was pulled from the market for safety reasons – a cautionary note about using new drugs.) The estimate is that companies spend between \$2.4 and \$4.8-billion annually here in pushing their drugs to doctors. While the Food and Drugs Act gives the federal government the power to regulate promotion it has consistently refused to exercise that power except on very rare occasions and has turned over the control of promotion to the drug companies. The results are not unexpected – a weak code of conduct en-

forced through a passive complaints mechanism with fines for violations that amount to little more than lunch money for the drug companies.

Back in the early 1990s, the government of New Zealand was looking at rapidly escalating drug costs. Its response was to create an agency, Pharmac, to manage the national drug budget. According to projections without Pharmac by 2009 the country would have been paying \$1.6-billion per year, with Pharmac it was actually paying about \$670-million. Steve Morgan, a health economist at the University of British Columbia, has estimated that if Canada adopted the tactics used in New Zealand, depending on what groups of drugs we are looking at, Canada could save 21% to 79% off what is currently spent. New Zealand is willing to play hardball with the drug companies. If companies want to list a new drug on New Zealand's formulary then they typically have to cut prices on drugs already listed. New Zealand aggressively uses reference-based pricing. Under this system where there are groups of drugs that experts judge are basically the same in terms of safety and effectiveness the government only pays for the least expensive drug in the class. British Columbia uses such a system for five groups of drugs and saves money without putting patients at risk. However, no new drug groups have been added since the NDP lost power in 2001 and no other province in Canada uses the system.

If the real savings are in lowering brand name drug costs why has the Ontario government chosen to take on the pharmacy owners? The answer lies in the power of the multinational drug companies. The pharmacy owners have relatively few allies. The multinational drug companies would not only complain to the

provincial government they would also complain to Washington and the European countries where they are based and where they contribute substantially to the economy. Canada has already lost a couple of complaints about drug prices at the World Trade Organization and is unlikely to relish the thought of taking on another challenge.

Bringing down generic prices is only a small part of controlling drug spending in Ontario and the rest of Canada. ♦

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THREE STEPS TO MAKE PHARMACARE A REALITY FOR ALL

Irfan Dhalla

When H1N1 influenza seemed poised to kill tens of thousands of Canadians, governments across Canada did a wonderful thing: they made the antiviral medication Tamiflu available free to anyone who needed it.

But why take an equitable approach to one prescription medication and continue the inequitable approach for all the rest?

The eligibility criteria in our current patchwork system make little sense.

In Ontario, for example, bank executives who are 65 or older have their medications paid for by government, while 64-year-old taxi drivers pay for everything on their own dime. With a considerable number of life-prolonging medications costing thousands or even tens of thousands of dollars per year, most people cannot afford to pay for these medications out of their own income or savings.

Most everyone agrees that leaving prescription medications out of medicare was a mistake. The thornier issue is how this mistake can be overcome.

Here are three things governments could do to take universal Pharmacare from dream to reality.

First, governments should focus relentlessly on effectiveness and cost when deciding what drugs to pay for and how much to pay for them.

Although there are reasonably robust national and provincial processes for assessing the effectiveness of new medications, governments rarely scrutinize older medications in the same manner. Some of these medications are only minimally ef-

fective and some are even harmful. For example, geriatricians have produced a list of drugs that are so harmful they should virtually never be prescribed to older adults. Yet not a single provincial drug plan has placed restrictions on most of these drugs.

Another area where there is obvious waste is in the pricing of generic medications. Why do we continue to pay flat rates of 50 per cent or more of the brand name price for generic medications when other governments, like Britain's, pay as little as 10 per cent? Pharmacies and generic drug makers are, of course, happy to share the excess profit – at taxpayers' expense.

Second, governments should do away with public subsidies for private health insurance.

Right now, most Canadians with steady jobs are provided with private health insurance by their employers. What many people don't know is that government subsidizes these plans because the employer's contribution is exempt from income tax. And because these subsidies are proportional to the highest income tax rate paid by an individual, those with the highest incomes benefit the most.

Many of these private plans (including my own) pay for non-essential services such as massage and naturopathy. At the same time, self-employed individuals with lower incomes have to pay the full cost of life-saving medications out of pocket.

These inefficient and unfair subsidies received considerable attention in the U.S. when Senator John McCain pledged to get rid of

them in his presidential campaign. Outside Quebec, however, they have received little attention in Canada.

Are there Canadian politicians courageous enough to follow Quebec's lead and vigorously campaign for the removal of the private health insurance subsidy?

A pharmacare program that covers everyone could be paid for in part by eliminating the private health insurance tax subsidy. But that won't be enough. The rest of the money should come from a courageous third step – an income-dependent insurance premium. Everyone who paid the premium would be treated the same way, just as with Tamiflu and H1N1. The new tax – let's call it what it is – might be a hard sell, but polls have repeatedly indicated that a sizable share of the public, often a majority, is willing to pay more for better health care.

Deliberative bodies like Ontario's newly formed Citizens' Council could be asked to consider this issue. And physician organizations could be asked to champion the new insurance premium if it were felt to be in the public interest.

The egalitarian impulse we had when faced with H1N1 was reassuringly Canadian. We were furious to discover that hockey teams and private clinics were getting the flu vaccine first, but pleased to know that Tamiflu would be available to everyone who needed it.

With federal and provincial budgets soon to be released, now is the time for governments to act on that Canadian impulse and build universal pharmacare. ♦

First published in the Toronto Star February 18, 2010

SCIENTIFIC FREEDOM AND RESPONSIBILITY AWARD FOR OLIVIERI

Gordon Guyatt

Dr. Nancy Olivieri has received a new award: she is the 2009 recipient of the “scientific freedom and responsibility award” from the American Association for the Advancement of Science. The award recognizes that Olivieri stood up “for the principle that patient safety and the integrity of research comes before any loyalties to commercial or institutional interests”. The award provides an opportunity to celebrate Nancy Olivieri’s heroism and to review the significance of her story.

In 1996 Dr. Olivieri, a Toronto hematologist and research scientist, identified an unexpected risk of a drug she was studying in industry-sponsored clinical trials involving patients with thalassemia, an inherited, potentially fatal blood disorder. When she moved to inform patients, the drug’s manufacturer Apotex Inc. prematurely terminated the trials. Simultaneously, the company issued warnings of legal action against her should she disclose the risk to her patients or anyone. Several months later, she identified a second, more serious risk through review of patients’ charts, and the company again issued legal warnings against disclosure. Despite the possible legal action by the company and the lack of effective assistance from her university and hostile attacks from the Hospital for Sick Children, Dr. Olivieri informed her patients and the scientific community of the risks she had identified.

The dispute became public in 1998 when Dr. Olivieri published her findings on the drug’s risks in the New England Journal of Medicine. Dr. Olivieri subsequently un-

derwent years of public attacks and attempts to discredit her that initially included the hospital, and continue to this day. Dr. Olivieri and a small cadre of supportive colleagues - who were also subject to harassment by the hospital - struggled to defend themselves against the aggressive and well-resourced attacks from the hospital and from Apotex.

A turning point in the battle occurred in 2001 when a panel of leading academics commissioned by the Canadian Association of University Teachers (CAUT) published their report completely vindicating Dr. Olivieri. This was followed shortly by exoneration from the Royal College of Physicians and Surgeons - to whom the hospital had complained about Dr. Olivieri - which concluded that Dr. Olivieri’s conduct was “commendable”. The university finally mobilized to support Dr. Olivieri coincident with publications in the New England Journal of Medicine and Nature Reviews and Science severely criticizing the actions of the hospital attacking Dr. Olivieri and the passive approach of the university regarding her defense. In November 2002, Dr. Olivieri reached a mediated settlement with the Hospital and the University, providing her with substantial redress for her grievances over unfair treatment.

Attacks on Dr. Olivieri have nevertheless continued. A 2005 book, highly publicized, attacked Dr. Olivieri, repeating discredited allegations. Most recently, Apotex has launched the latest lawsuit against her in an attempt to avoid complying with the terms of the 2004 settlement, including payment \$800,000 to Dr. Olivieri. The lawsuit has been

accurately characterized by CAUT executive director James Turk as a blatant attack on academic freedom.

Dr. Olivieri’s suffering, and her heroism, have not been in vain. The Olivieri case was a catalyst for the University of Toronto and its affiliated teaching hospitals to change their policy on industry-sponsored research. The revised policy ensures that in matters of human health, scientists can no longer be prevented from disclosing risks to patients in a timely manner. In part in response to the Olivieri case, the editors of the leading international bio-medical journals have imposed new standards for authorship. Authors must have access to the raw data from clinical trials, must have substantial involvement in the work, must not be impeded by contractual agreements from freely publishing their findings, and must disclose all potential conflicts of interest.

Much remains to be done to protect the academic freedom of clinical researchers, and to protect the public from misleading, and at times frankly distorted and selective reporting of research by the pharmaceutical companies. Nevertheless, Dr. Olivieri’s courageous actions have provided a beacon for a mobilization that has highlighted the issues, led to considerable action, and that continues today. The latest recognition of her determination to act in the interests of her patients and ignore threats to her own well-being once again highlights her model for exemplary action in a world in which public interest and self-interest are often at odds.♦

MAINTAINING PRESSURE FOR EQUITY FOR PATIENTS AT THE OMA

Member Ritika Goel wrote the President of the OMA April 19th, 2010 to encourage them to join the lobby effort on eliminating a discriminatory OHIP ruling which has impacted on access to health care for recent immigrants.

Dr Suzanne Strasberg, President
Ontario Medical Association
150 Bloor Street West, Suite 900
Toronto, Ontario, M5S 3C1

Dear Dr Strasberg,

On behalf of the Medical Reform Group, a group of physicians, residents and medical students, committed to high quality health care for all Canadians, we are writing to express our support for a recent motion brought to the OMA council. The motion reads:

“That the OMA encourage the Government of Ontario to follow the lead of the Government of Quebec in exempting newly landed immigrants from the three month wait for OHIP for cases of pregnancy, domestic violence and serious infectious disease.”

A large proportion of MRG members reside in Ontario. Thus we felt it appropriate to inform you of our positive view of this motion and our hope that the OMA will act further to ensure that policymakers modify existing barriers to care for newly landed immigrants. The three month waiting period policy is one that has caused many hardships, emotional, physical and financial, for new immigrants who are already facing multiple challenges in settling in to a new community. We see this motion as an essential first step to raising issues for new immigrants, and would further support a call to a complete end to the three month waiting period.

New immigrants in the three month waiting period often delay seeking care due to inability to pay, or are left no choice but to seek care and thus incur devastating financial consequences. This waiting period policy until recently, was present in Ontario, British Columbia, Quebec and New Brunswick with Quebec having exclusions in the cases of pregnancy, serious infectious disease and domestic violence. There are however, along with the OMA motion, several new developments on this issue as of late. Since the motion was put forth, New Brunswick has eliminated its three month waiting period for new immigrants and returning Canadians. The NDP is also currently in the process of drafting a private members' bill to propose eliminating this waiting period in Ontario. While we feel the OMA motion suggesting modifying our system to emulate the exceptions in Quebec is a positive step in the right direction, we feel the ultimate solution is complete elimination of the three month waiting period.

As Canadians, we value our health care system that operates on the principles of equity and accessibility for all. As such, we feel such a waiting period policy that causes the newest members of our society to choose between seeking care and serious financial or physical consequences is unfair and contrary to fundamental principles of equity. As OMA members, we also feel this is a policy that can cause significant difficulty for physicians who wish to advocate for patients but feel unable to do so due to the policies in place.

We are very proud that the OMA passed the resolution in favour of abolishing the three-month waiting period for OHIP for people in specific categories (pregnancy, domestic violence, infectious disease), and hope that the OMA in accordance with current political movement advocates for a complete abolition to this waiting period. ♦

LETTER TO PREMIER MCGINTY

In the wake of the provincial budget, Steering Committee member Ahmed Bayoumi sent on April 19th, 2010 the following commentary on the province's poverty reduction to the Premier and Minister of Community and Social Services.

April 19, 2010

Hon. Dalton McGuinty
Premier of Ontario
Queen's Park
Toronto, Ontario

By fax

Dear Premier McGuinty,

The Medical Reform Group, an association of progressive Ontario physicians with a long track record of defending our publicly funded health care system and speaking out on issues that impact on the health and well-being of Ontarians. We support using a progressive taxation system to provide essential services such as health, education, and social assistance. We are writing to express our concern over the recent Budget announcements to eliminate the Special Diet Allowance and provide only a 1% increase to social assistance rates.

We support the current review of social assistance in Ontario and are looking forward to the recommendations of Gail Nyberg and her colleagues. In the meantime, however, it is very worrying to us that the poorest of the poor in this province are not receiving an adequate income and, are in fact, at greater risk of illness and poor health because of the level of deprivation that they experience.

Many in the province have been advocating for an increase to the monthly social assistance rates that would make it possible for individuals on social assistance to access adequate shelter and nutrition. Those increases could take various forms: across the board increases, the addition of a Healthy Food supplement, an increase to the basic needs portion of the allowance that reflects the true cost of shelter and food, the use of vouchers, the supply of nutritious food through school programs, an increase in social housing supply etc. Following the 2001 death of a Sudbury woman, Kimberley Rogers, a 40 year old student who was 8 months pregnant at the time, the following recommendation was made by the Coroner following the inquest into Ms Rogers' death:

The Ministry of Community, Family, & Children's Services and the Ontario Works Program should assess the adequacy of all social assistance rates. Allowances for housing and basic needs should be based on actual costs within a particular community or region. In developing the allowance, data about the nutritional food basket prepared annually by local health units and the average rent data prepared by Canada Mortgage and Housing Corporation should be considered.

Rationale: To ensure that social assistance rates are adequate and adjusted annually if necessary.

It is our hope that your government will revise and increase the Ontario Works (OW) and Ontario Disability Support Program (ODSP) rates so that they are based on actual living costs, including housing and food. As well, OW and ODSP rates need to be indexed annually to reflect inflation, especially if, as predicted we are entering a time of rising food costs.

The Basic Allowance includes a nutrition allowance which should meet the daily nutritional needs as determined annually by the cost of the Nutritious Food Basket, calculated by each of Ontario's 36 public health units, with the remainder set to enable recipients to afford other basic needs including transportation, clothing, and personal care items.

In addition, since housing costs demand the lion's share of monthly incomes, we ask that the shelter component maximum for OW clients be set at 85 – 100 percent of the median market rent for each local housing market, based on annual surveys conducted by the Canadian Mortgage and Housing Corporation.

As physicians who care deeply about the public good, we know that improvements in health outcomes of the more than 1.5 million Ontarians living below the poverty line will have a significant positive impact on overall population health. This will in turn reduce pressures on the overextended public health care system and contribute to the current government's stated goal of making Ontarians the healthiest Canadians.

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LETTER TO PREMIER MCGUINTY (CONTINUED)

In 2009, a report entitled *Sick and Tired: The compromised Health of Social Assistance Recipients and the Working Poor in Ontario*¹ found higher rates of chronic disease and poor health in social assistance recipients when compared to the non-poor. In some cases, these rates were 7.2 times higher. Despite this, people living in poverty were less likely to have a regular medical practitioner or to use preventive health services. Addressing and preventing poverty makes good sense: it is a long term investment in the future of Ontario's population, especially its children.

We know you have made a commitment to reducing poverty, and that you have prioritized children first. We remind you that poverty is not just limited to children and wish you success and speed in your ability to make a difference. But, the changes you announced in the recent Budget will not make lives healthier for the poorest of our population. We hope that the findings and recommendations of Ontario's social assistance program will provide you with the information you need to do the right thing. We believe the right thing includes a significant rise in rates and an end to the chronic hunger and deprivation that many recipients now face.♦

¹ Wellesley Institute, Community Social Planning Council of Toronto, University of Toronto. *Sick and Tired: The compromised Health of Social Assistance Recipients and the Working Poor in Ontario* accessed from <http://socialplanningtoronto.org/reports/sick-and-tired-report-released/> March 15, 2010

Ontario Budget 2010

Janet Maher

Finance Minister Duncan calls his March 25th budget a 'balanced approach' but that is hard to see from the point of view of those marginalized Ontarians who must rely on social assistance or disability support. For those for whom paying the rent and feeding the kids have been competing priorities since the Liberals returned to power in Ontario, this year's budget was especially bitter medicine.

Ignoring the province-wide lobby for a monthly food supplement to recognize the links between income and health, the budget limited the increase in benefits to one per cent. An added change was the elimination of the Special Diet allowance which has been the subject of considerable debate, and a rather specious review by the Ontario Auditor General. Duncan promises that the Minister of Health will be responsible for designing a new benefit to be administered through her department.

Slightly better news for Ontarians were announcements on the expansion of day care subsidies to fill the gap left by the federal government, a few more timid steps toward full-day learning for four and five year olds, and a recognition that Ontario's universities and colleges are bursting at the seams with support to add 20,000 new spaces in 2010-11.

Even such a conservative institution as the Conference Board of Canada, cited by the Finance Minister in his budget speech, disagreed with the dismal economic outlook for 2010-11 painted by the Ontario Finance Minister, urging the government to be more realistic in its deficit reduction plans. The Canadian Centre for Policy Alternatives in its Ontario Alternative Budget 2010 technical papers, even goes so far as to characterize the deficit and recession talk as a 'useful' crisis in that it allows the Ontario government to ramp up the

rhetoric around the province's credit rating while doing almost nothing constructive to protect it.♦

BUILDING A CULTURE OF PATIENT-CENTRED CARE

Gary Bloch, Ahmed Bayoumi, Ritika Goel, Gordon Guyatt recently prepared this briefing note for discussion in the public debate around the CMA Blueprint document released at the 2009 CMA annual meeting

In 1966, the United Nations General Assembly proposed the “Covenant on Economic, Social and Cultural Rights”, which Canada ratified in 1976, that affirms “The right of everyone to the enjoyment of the highest attainable standards of physical and mental health... through the conditions which would assure to all medical services and medical attention in the event of sickness.”²⁵ The World Health Organization’s Commission on the Social Determinants of Health recently issued its final report, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, which recognized that health care was one of many social determinants of health that are important for advancing health equity, alongside social and political factors, and that health equity was fundamental to achieving social justice.⁹

The right to health represents a deeply held belief among most Canadians. As ethicist Nuala Kenny has pointed out, what may have been dry policy initiatives of the Canada Health Act in fact captured the Canadian imagination, and have taken on strong symbolic value for Canadians. Communitarian values, and a notion that individual good of others represents a social good from which we all benefit, underlie the value of equity in health care. The notion that health has a special value, and that therefore health care represents a service fundamentally different from other services, represents an essential ethical standard.¹⁸

Despite economic tensions, Canadians continue to place a high

value on equity in health care delivery. In 2002, the Romanow *Commission on the Future of Health Care in Canada* investigated the values of Canadians in regard to our health care system and determined that Canadians place a high value in equity. Indeed, Canadians assigned the highest priority to universal access based on need. In the report, Romanow stated: “Almost all Canadians I have heard from to date want to ensure that the poorest in our society have access to health care.”²⁵

When equity is not given a high value, consequences are dire

The experience of the United States, which continued to maintain a largely privatized health care system after Canada turned to Medicare in the 1970s, has shown how a private system is not only inefficient but, most importantly, results in inequitable health and health care.

Two studies have been published in prominent public health journals in recent months linking increased mortality with the insurance status of Americans. In the first study, investigators analyzed records of 23 million children that found an excess relative mortality of 37.8% in the uninsured.¹ The second study presented data suggesting 45,000 deaths annually are associated with a lack of health insurance in the U.S.³⁰ Previous investigations have established that those without insurance are more likely to die prematurely from conditions such as breast, cervical, colorectal, prostate cancer and melanoma. They also have significantly worse outcomes in chronic

diseases such as diabetes, cardiovascular disease, HIV infection, end-stage renal disease and mental illness.⁷

Not only have the uninsured had difficulty with health care in the U.S. but so have those who were insured. Harvard University investigators found that 46% of personal bankruptcies in the U.S. in 2001 and 62% in 2007 were due to medical bills. The majority of these bankruptcies were filed by those with middle-class incomes and three quarters of them were actually insured.¹⁵

A study that directly compared the difference between equity of outcomes in Canada versus the U.S. looked at the survival rates of breast cancer in Ontario in comparison to California. The study showed that breast cancer survival was linked to income in the United States with a significantly lower survival rate for those in the lower socioeconomic group. The investigators found no such gradient in Canada, and attributed this to the Canadian universal health care system.¹⁴

The needs of vulnerable Canadians demand a commitment to equity

Recognition of the health status of vulnerable populations, and the role of physicians in addressing their needs are necessary to maximize the impact of a patient-centered charter. While all patients deserve patient-centered care, it is for members of vulnerable groups that patient-centered interactions and health planning can have the greatest

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BUILDING A CULTURE OF PATIENT-CENTRED CARE (CONTINUED)

health impact. This charter should make a commitment to use resources to reduce health disparities and provide targeted, quality health care for vulnerable groups.

High quality evidence indicates that those who are part of vulnerable or marginalized groups in Canada suffer from significantly worse health outcomes.^{5,22} People who live in poverty have poorer health in major indicators such as life expectancy, low birth weight and infant mortality; and higher incidence of, and morbidity from, chronic physical and mental health conditions.^{23, 28, 29} Children who grow up in poverty have worse short-term health and social outcomes, and suffer the health effects of that poverty throughout their lives, even if their family income subsequently rises from the poverty level.¹⁰ Single parent-led families and people with disabilities are at significantly higher risk of living in poverty than the general population.^{6,24}

While poverty is a common landing point for vulnerable groups, certain specific groups warrant targeted attention to address inequitable disparities in health.

- Aboriginal people continue to suffer from dramatically worse access to care and poor quality of care compared to other Canadians.^{13,17} First Nations people experience markedly lower life expectancy, higher infant mortality, and higher rates of injuries, suicide, and diabetes.²

- Immigrants, especially those with low income, have much lower rates of screening and preventive health services.^{20,26} There is a growing trend toward a racialization of poverty, especially in major cities, and health interventions must recognize race-based disparities.²¹

- People without health insurance are at high risk of poor outcomes

due to lack of access to health care. This group includes recently arrived refugees; new immigrants to Canada who face a three-month waiting period in Ontario, B.C., Quebec and New Brunswick before they are eligible to apply for insurance; and people who have no or are awaiting immigration status.⁸

- People without secure housing are at particularly increased risk of having unmet health care needs.¹⁹ Homeless individuals have far higher rates of chronic and acute mental and physical illness, lower life expectancy, and higher health care use, than the general population.^{12,16}

Physicians Have an Important role in Health Inequity

The medical community has a strong role to play in alleviating the health impacts experienced by these vulnerable groups. Investment in services for low-income, vulnerable populations is associated with decreased health disparities.¹¹ Policy analyses have shown that tailored models of care are necessary to ensure adequate access to care for this highly marginalized population.²⁷ Physicians have multiple direct roles to play in reducing health disparities, through targeted lobbying of policymakers, specific restructuring of their practices, and through direct knowledge of interventions with vulnerable individual clients that will decrease the health effects of their marginalization.^{3,4}

The Charter should recognize three types of equity as crucial to patient-centred care

A patient-centered charter should explicitly recognize the health needs of these populations, and commit to specific interventions to decrease the inequities in health

experienced by these groups. This will ensure the patients who need care the most receive it, and that the maximum potential health impact of the charter is realized.

Given the values of Canadians, the ethical imperative of equitable health care, and the special needs of vulnerable populations, a health care charter should explicitly commit to three types of equity.

Equity in opportunity refers to individuals having equal chance to obtain health care if they so choose without financial barriers. To a large extent, our publicly funded health care system provides this for physician and hospital services, although there are some groups who remain uninsured and some barriers to care such as block fees. As the CMA has recognized, we do not have equality in opportunity for other services, including drugs, dental care, and home care, and this is problematic. Equity in opportunity is the fundamental aspect of equity to which the charter should commit.

Equitable access refers to barriers that may present themselves to use of health care such as transportation, stigma and language. These are frequently issues for marginalized populations. Physicians should recognize, and commit to help ameliorate, barriers to equitable access through considering how they operate their practices and working with administrators to address structural barriers to accessing health care.

Equity of outcomes refers to an equal standard of health. To truly have equity, we should not only provide opportunity and access, but take measures to ensure equal health outcomes at the end of the day. This may mean directing resources preferentially to groups known to

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BUILDING A CULTURE OF PATIENT-CENTRED CARE (CONTINUED)

have worse access or outcomes. In the CMA's vision and blueprint for health care transformation, we strongly encourage commitment to strive for equity of health outcomes.

Conclusions

Reports, polls, and focus groups consistently reveal that Canadians demand that equity be a core principle of our health care system. Ethical principles, and recognition of the poorer health status and greater health needs of vulnerable populations further mandates equity as a core principle of any charter developed of patient-centred care. Enshrining equity into the charter for patient-centred care will place the Canadian Medical Association at the forefront of working towards a health care system that provides patient-centred care for all Canadians. ♦

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MYTH: MOST PHYSICIANS PREFER FEE-FOR-SERVICE PAYMENTS

Since the introduction of Medicare in 1966, physicians in Canada have operated as independent, self-employed entrepreneurs, billing their provincial ministries of health and other payers for each insured service they provide. This payment method – commonly called fee-for-service – reimburses doctors for each of their clinical activities, based on a set of billing codes established by the payer.

Fee-for-service is believed to be the payment model most trusted by physicians, possibly because it reflects their desire for professional autonomy.¹ However, some doctors may also prefer this form of payment because it enables them to use fee-for-service billing to generate more revenue. This tactic arguably drives the “one problem per visit” policies adopted by a number of family doctors.² Recent decades have seen the introduction of alternative payment plans such as salary, capitation (under which doctors receive a yearly fee for each patient on their roster) and blended models (which combine multiple payment schemes). More recently, some payers have introduced new payment plans as part of a primary healthcare reform agenda that promotes interdisciplinary team-based care, with the goal of improving accessibility and comprehensiveness of care.³ It is generally understood, however, that any shift in the way doctors are reimbursed requires their voluntary buy-in; accordingly, some payment plans offer financial incentives to further entice physicians to make the switch.

New physicians, new preferences

In contrast to conventional wisdom that physicians prefer only



fee-for-service, research shows that a growing number of Canadian physicians are interested in alternative payment models. According to the National Physician Survey (the largest survey of Canadian doctors), the percentage preferring fee-for-service as their sole source of income declined from 50% in 1995⁴ to 28% in 2004⁵ and to 23% in 2007.⁶ The preference for non-fee-for-service is even more pronounced among female physicians, only 18% of whom preferred fee-for-service compared to 26% of their male colleagues. Age also appears to be a factor: support for fee-for-service ranged from a high of 41% among physicians aged 65 or older to a low of 17% among physicians under 35.⁶ As older, predominantly male, cohorts of physicians retire, support for fee-for-service as the sole source of income is expected to fall even more rapidly.

The growing popularity of alternative payment plans is also reflected in medical billing trends. From 2001 to 2002, clinical payments under alternative plans rose 40% and accounted for 16% of total physician clinical service costs.⁷ The percentage of physicians receiving at least some of their income from non-fee-for-service arrangements also rose: between 2000 and 2006,

the figure increased from 28.1% to 39.1% of all Canadian physicians.⁸

As well, work satisfaction data indicate that physician support for fee-for-service arrangements may be weak. For example, a 2006 Canadian Institute for Health Information report found a correlation between higher income share from fee-for-service arrangements and lower physician satisfaction with professional lives.⁹ Meanwhile, Green et al. (2009) found higher levels of satisfaction among physicians working in capitation and salaried environments, compared to their fee-for-service counterparts.¹⁰ However, this is not to say that physicians have enthusiastically embraced non-fee-for-service payment models, even if they recognize that change is needed. A 2004 survey of Ontario family doctors reported that 60% agreed that the financing of primary care requires change, but less than half of respondents felt well-informed enough about new capitated models (part of the province’s proposed Family Health Networks) to make a decision to join, and many opposed specific elements of primary healthcare reform, such as financing incentives for prevention or extending operating hours.¹¹

Compensation for comprehensive care

Satisfaction with alternative models may be due in part to the accompanying financial premiums designed to encourage physicians to change their practice model. Indeed, Green et al. (2009) found that physicians who switched from fee-for-service to an alternative payment model saw their incomes increase as much as 30% (depending on the model

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MYTH: FEE FOR SERVICE (CONTINUED)

chosen); whereas physicians who stayed in traditional fee-for-service environments, with minimal changes in the type or volume of services provided, saw minimal increases or decreases in their income over the same period.¹⁰ The higher level of pay under alternative payment models is often a result of incentives to doctors to deliver certain types of services.

Fee-for-service practice is sometimes criticized for discouraging physicians from offering comprehensive or whole-person care in favour of high patient volume,² while some alternative plans reward physicians whose patients do not seek out other sources of primary care, such as the ER or another family doctor.¹² Access to care has been identified as a problem for practices operating within the fee-for-service payment model; Chan (2002) has documented reductions in the provision of obstetrics, nursing home visits, hospital inpatient care, and house calls by family doctors.¹³ Alternative payment plans, by contrast, often include a variety of incentives to encourage physicians to provide after-hours care, obstetrics and hospital visits.³ However, given that the alternative plans have been introduced only in the past five to 10 years and in some, but not all, provinces, there is limited research available to assess their impact. Existing evidence indicates only modest differences in patient outcomes and service delivery.^{3, 12, 14}

Governments see alternative models as offering greater flexibility in achieving health human resources and health policy goals. Alternative models have long been recognized as desirable for physicians practicing in rural and remote communities too, where demand for medical ser-

vices is often low and unpredictable, while the personal and professional costs of a rural practice can be quite high.¹⁵ Another much-touted function of alternative payment models is that they encourage new practice models, primarily team-based medicine and preventive care.³ Alternative models also purportedly accommodate valued non-clinical activities like teaching and research, or the administrative overhead associated with adopting electronic medical records.¹⁶

Conclusion

The modern physician is moving toward an alternate form of payment plan. However, it would be premature to sound the death knell of fee-for-service; when respondents to the 2007 National Physician Survey were asked to define their ideal blended payment plan, 82% included a fee-for-service component.⁶ Some payers require fee-for-service “shadow billing” in order to monitor changes in cost and service provision between the fee-for-service model and newer, alternative models of payment.

A decade-old green paper from the College of Family Physicians of Canada argues that flexibility in payment models is imperative: “A one-size-fits-all approach is a straightjacket for both the patient and the physician.”¹⁷ Blended systems offer a range of payment and policy options, each of which will have varying attractiveness to physicians, politicians and patients. The challenge is to determine which models deliver the greatest overall benefits – to patients, taxpayers and healthcare providers.♦

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REALITY CHECK ON HEALTH-CARE COSTS

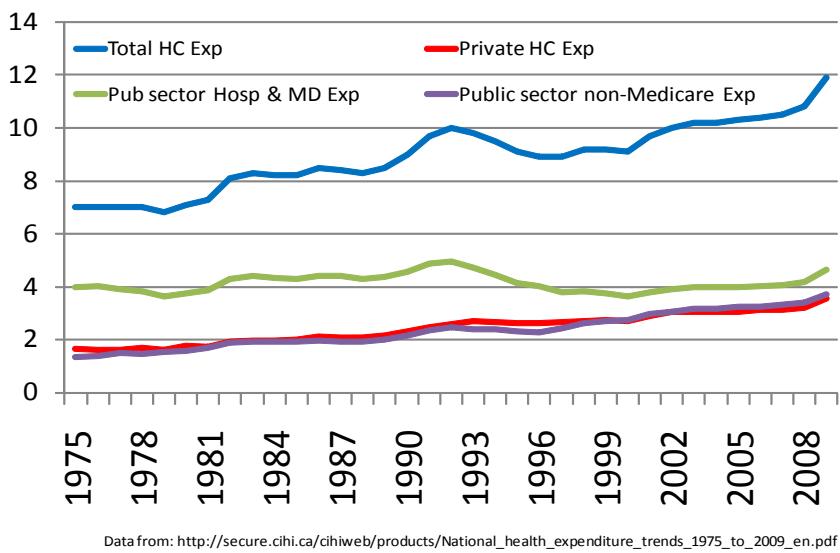
Michael Rachlis says despite the rhetoric about unsustainability, privatization and user fees are not the answer.

Medicare is as sustainable as we want it to be. The headlines scream health-care costs are out of control. Last week's Quebec budget floated the notion of user fees. At the Montreal Liberal policy conference, David Dodge, former governor of the Bank of Canada, spoke for many when he claimed that the only options were higher taxes, user fees or poorer services.

However, noted UBC economist Robert Evans reminds us to be wary of the rhetoric of unsustainability setting up limited choices. In fact, a closer examination reveals that medicare's expenses have been relatively stable and the best cost-control option focuses on enhanced quality.

During the depths of Canada's last serious recession in 1992, Canada spent 10 per cent of its economy on health care. Canadians were concerned and governments froze budgets. Then the economy boomed. Five years later, we spent less than 9 per cent of GDP on health. In a few years, we became concerned about underfunding. Governments had lots of money and we deliberately ramped up spending.

Canadian Health Care Exp as % of GDP



Data from: http://secure.cihi.ca/cihiweb/products/National_health_expenditure_trends_1975_to_2009_en.pdf

By 2009, another recession year, health care took 12 per cent of our GDP. Provinces started turning off the taps. But last week's numbers indicate the economy is on fire. In a few years, health care's share of GDP will fall again.

There's even less sign of cost pressures if we look at public spending. Only about two-thirds of Canadian health care is directly funded by the provinces and their costs barely increased over those 17 years from

6.9 per cent to 7.7 per cent of GDP. Furthermore, the Canada Health Act covers only hospitals and doctors. The costs of those programs have actually decreased from 5.3 per cent to 5 per cent of GDP.

It's the non-medicare costs that are out of control. Drug spending increased from 1.2 per cent to 2 per cent of GDP and there have been steep increases also for dental and optical services. Not coincident-

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REALITY CHECK ON HEALTH-CARE COSTS (CONTINUED)

ly, these sectors mirror the U.S. multi-payer health system. Government covers a minority of costs. There are high administrative expenses. Prices are inevitably higher without a single payer. And many Canadians suffer grievously because they can't afford needed care.

More important, there are many choices available besides additional spending or less service. In 2003, the Ontario Drug Benefit plan spent \$65 million for Vioxx, an anti-arthritis drug. The next year, it was withdrawn from the market because it was linked to heart attacks. Not only was Vioxx more dangerous than alternatives like ibuprofen, it was 50 times more expensive. While we were telling seniors there was no money for home care, we poured \$60 million down the drain and hundreds of Ontarians died premature deaths.

Health care is replete with waste. Fifteen per cent to 20 per cent of patients with heart failure are readmitted to hospital within one

month of discharge. Simply ensuring home-care nursing follow-up would eliminate half the readmissions, save hundreds of lives and avert costs of \$2,500 per patient.

These problems are not due to incompetent or uncaring doctors or nurses. Rather, as we've been told for decades, the structure of our health system puts patients in persistent peril.

Transitions from the community to hospital to nursing home rival the complexity of getting a visa to visit North Korea. Our computerization of health records lags every other wealthy country. Nearly 40 years after a landmark Burlington-based study of nurse practitioners, less than 10 per cent of Ontarians have access to these cost-effective providers.

Health policy experts conclude that improving quality is the key to sustainability. High performing organizations like the U.S. veterans health system have demonstrated it is possible to simultaneously improve

quality, enhance services and control costs.

Barack Obama will shortly nominate Boston pediatrician Dr. Donald Berwick as administrator of the Centers for Medicare and Medicaid Services. Berwick is currently president of the Institute of Health Care Improvement. IHI's principles guided the veterans system's journey to excellence as well as influencing other organizations around the world, including many in Ontario.

CMS funds the U.S. medicare and medicaid programs, one-third of U.S. health-care spending and four times all Canadian health-care expenditures. Obama and Berwick may be about to restructure the U.S. system around quality principles.

Canadians should be somewhat concerned about our health system's costs. But the road to sustainability runs through improved quality, not user charges or privatization. ♦

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NHS HAS SEEN LITTLE BENEFIT FROM MARKET REFORMS, SAYS THINK TANK

Zosia Kmietowicz

Eight years after Labour introduced market forces into the NHS the health service is still not seeing the desired returns for its investments, a review of the evidence indicates.

The report from the independent think tank Civitas concludes: "The available research indicates that the NHS may have found itself in a lose-lose situation-taking on the extra costs of competition without experiencing the benefits."

Introducing market forces into the NHS should have led to better responsiveness of providers to pa-

tients and purchasers, to reduced costs, and to innovations in the way services are delivered. But evidence that any of these have materialised is scant.

For their review the researchers found very little research on the cumulative effects of market reform in the NHS since 2002, although numerous studies have looked at the effects of individual policies.

These showed that waiting times in the NHS have fallen in the past eight years, access to health services has improved, and the efficiency of providers has increased.

But there are many problems, said the review. Providers remain all too powerful, as commissioning by primary care trusts remains weak; innovation is largely non-existent; the payment by tariff system encourages providers to be no more than average; hospitals are incentivised to reduce demand inappropriately; and collaboration among healthcare professionals and organisations has been undermined.

Overall, staff have been demotivated by the endless stream of market reform policies, and the

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NHS HAS SEEN LITTLE BENEFIT FROM MARKET REFORMS, SAYS THINK TANK (CONTINUED)

public neither understands nor supports market based reforms, the review says. And it is “questionable” whether the positive changes seen in the NHS since 2002 are due to market forces alone, it says. Other factors, such as increases in funding, targets, and weak monitoring played a big part.

Laura Brereton, a health policy researcher at Civitas and one of the report’s authors, said, “Market based reform in the NHS promised great

things, but, as things stand, it has yet to bring about the benefits we see from markets in other industries in any comprehensive form: increased responsiveness to customers; better quality; improved efficiency; and innovation.”

James Gubb, director of the health unit at Civitas, said, “This review could not have come at a more important time, when debate about the future of the market in the NHS is intensifying and finances are start-

ing to bite.

“More work is needed, but it is clear there have been both benefits and costs. Whilst the NHS is better than it was in 2002, wavering commitment to the idea of a market has unquestionably stymied the impact it could have had.”♦

First published 1 March 2010, doi:10.1136/bmj.c1194 British Medical Journal News. The Impact of the NHS Market: An Overview of the Literature is at www.civitas.org.uk/nhs/download/Civitas_LiteratureReview_NHS_market_Feb10.pdf

15 BY 15: EARLY HUMAN CAPITAL INVESTMENT IN BC

As the Steering Committee was assembling its briefing note on the CMA blueprint, Clyde Hertzman drew our attention to the policy framework document he co-authored with the Human Early Learning Project (HELP) at the University of British Columbia; highlights of the document are excerpted here

The stock of human capital in British Columbia is key to its long-term economic success. This means early child development is a critical issue for business leaders, because the years before age six set in motion factors that will determine the quality of the future labour force. Today, only 71% of BC children arrive at kindergarten meeting all of the developmental benchmarks they need to thrive both now and into the future: 29% are developmentally vulnerable.

While the poor are more statistically likely to be vulnerable, the majority of vulnerable children in BC reside in the more populous middle-class. Early vulnerability is a middle-class problem. A rate of child vulnerability above 10% is biologically unnecessary. At three times what it could be, the current vulnerability rate signals that BC now tolerates an unnecessary brain drain that will dramatically deplete our future stock of human capital. Economic analyses reveal this depletion will cause BC to forgo 20% in

GDP growth over the next 60 years. The economic value of this loss is equivalent to investing \$401.5 billion today at a rate of 3.5% interest, even after paying for the social investment required to reduce vulnerability. Unnecessary early vulnerability in BC is thus costing the provincial economy a sum of money that is 10 times the total provincial debt load.

The implication is clear: governments, businesses, bankers and citizens have ten times as much reason to worry about the early child vulnerability debt as we have reason to worry about the fiscal debt. Reducing early vulnerability is therefore necessary for BC to secure its long-term economic future, while it will also inject a significant economic stimulus now. Some may hold out hope that we can compensate for high early vulnerability by increasing investments in the final years of school, in expanding post-secondary education, or in job skills training for adults. However, human development research warns against this hope because it ignores the genetic

and biological reality of the human species: the early years represent the unique window in the human life course during which citizens’ physical, socio-emotional and cognitive potential are especially malleable to the positive effects of strategic human capital investments. The interaction of nature and nurture “sculpts” the developing brain and other biological systems such that children who do not benefit from optimally nurturing early environments risk genetic adaptations that will limit their life-long well-being and productivity.

The early development research is now so compelling that there is a growing consensus among economists, such as Nobel Laureate James Heckman, that the most cost-effective human capital interventions occur among young children. Heckman (2008) concludes that “a major refocus of policy is required to capitalize on knowledge about the life cycle of skill and health formation and the importance of the early years in creating inequality in America and in

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producing skills for the workforce."

Recognizing the importance of early human capital investments, the Government of British Columbia's (2009c) Strategic Plan commits to lowering the provincial rate of early vulnerability to 15% by fiscal year 2015/16. This *15 by 15* goal is an ambitious but reasonable signpost along the way to our ultimate goal of reducing early child vulnerability to 10% by 2020. Presently, however, 93% of BC neighbourhoods have vulnerability rates that exceed even the intermediate target of 15%. Significant changes across the entire province are therefore required to create broad and equitable access to the conditions that help children and families thrive.

The requisite public policy response is a bold one. BC suffers unnecessarily high early vulnerability across income classes because it is relying on old post-war thinking to address 21st century social and economic issues. In the absence of a system of early learning and child care services, public policy in BC and much of Canada remains nostalgic for a time when some women stayed home to rear young children while some men served as sole breadwinners on behalf of their families. This nostalgia ignores the current reality: most mothers today are employed, helping to compensate for real declines in male wages, or in order to stave off persistently high rates of child and family poverty. As mothers allocate more time to employment, households struggle with less family time, in part because fathers have not managed to fill the care void. For men and women alike, work/life conflict is pervasive irrespective of earnings, and time to care personally is a common casualty.

New policy thinking is there-

fore in order. International research reveals that the best strategy to reduce early vulnerability is found in comprehensive government policy which supports parents (men as much as women) to synchronize caring and earning. The implications of this research for BC means citizens and businesses must support governments to invest \$3 billion annually in the following *15 by 15* Policy Framework for Optimal Early Human Development. Half of the \$3 billion investment will support families to enjoy more time and resources to care personally, while the other half will strengthen community services.

The reality of early human capital development, however, is that population-level improvements generate significant economic growth only after children work their way through the elementary, secondary and (sometimes) post-secondary education systems to transition into the labour market. Therefore, it will be 14 years before even the first cohort of children reaping the human capital gains from the proposed *15 by 15* investments will personally contribute dividends to the economy. Clearly, this investment strategy requires patience as a virtue.

In response, we propose policy changes that will allow individuals and businesses to recoup a substantial portion of the investment costs in relatively short order: from 33% to 62% of the requisite expenditure during the first electoral cycle; and from 39% to 47% of the expenses over the first three electoral cycles. Given these benefits, the net cost to taxpayers will only be three-quarters of the gross investment.

Immediate returns are maximized when policy innovations support the adults who care for the future stock of human capital as

much as the children themselves. These adults can benefit now from the policy reforms and thus generate real economic returns much more quickly than will human capital investments in young children alone. Short- and medium term benefits include:

- productivity gains from accelerated labour supply, especially among women
- productivity gains from reduced absenteeism as a result of improved work/life balance
- health cost savings associated with improved work/life balance
- health cost savings associated with poverty reductions
- child welfare savings, as fewer children enter the foster care system
- reductions in crime, and government expenditures on the justice system
- economic stimulus, when invested during an economic recession

In short, the *15 by 15* Policy Framework proposes a fundamental shift in how we think about health care and human capital. We recommend shifting from treating illness after the fact, to promoting health from the outset of the human life course. The research evidence makes clear that this shift will accelerate economic growth enormously over the long-term, and that the economic case for the *15 by 15* Policy Framework is solid even in the near- and medium-term. The following paper provides a detailed blueprint for policy reform, and offers HELP's world-renowned monitoring and evaluation capabilities to guide the way.

The private sector, including business, stands to capitalize the most from the economic growth that well-designed family policy will generate. It is therefore time for the

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15 BY 15 (CONTINUED)

BC business community to actively join the call for evidence-based human capital investments which target the life course stage that will pay the greatest return: when parents and communities care for citizens in their

early years. Only this bold policy reform will prevent the brain drain that is most threatening to our economy: the future human capital losses that result from high child vulnerability today.♦

For more information on HELP and a copy of the full framework document see: <http://beta.earlylearning.ubc.ca/research/initiatives/key-messages/15-by-15-smart-family-policy/>

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MEDICARE: SOLUTIONS FROM WITHIN

Saturday, May 15, 2010; 9 am to 2 pm: Faculty of Law, University of Toronto
Requires pre-registration at medicaresolutions.eventsbot.com

Speakers/Resource People:

- Dr. Raisa Deber, Health Care In Canada: An Introduction to the System and the Debate:
- Dr. Joel Lexchin, Can We Afford to Cover Drugs For All? A discussion about Pharmacare: Headlines or Ontario Health Coalition and Dr. Nan Okun, Hot Air? - Wait Times, ER Closures, Small Hospital Cuts, User Fees
- Dr. Rosana Pellizzari, An Ounce of Prevention Moving Away From An Illness Model, Addressing Health Equity and Poverty in a Public System
- Steven Shrybman and Lorian Hardcastle, Is That Legal? Current Breaches of the Canada Health Act
- Dr. Michael Rachlis, Better Medicare: Public Solutions to Medicare's Problems

MRG members are invited to gather with conference organizers for social event following the conference on Saturday, May 15th. This event is co-sponsored by Students for Medicare and the Medical Reform Group.

For more information: studentsformedicare@gmail.com or medicalreform@sympatico.ca or 416 787 5246.

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Please visit and comment on our web-site at <http://www.medicalreformgroup.ca>

Please also make a note of our current contact information as follows:

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